CHAPTER 4

HEALTH RECORDS AND FORMS

PAGE

SECTION A - HEALTH RECORDS

PURPOSE AND BACKGROUND 1
CONTENTS OF HEALTH RECORDS 1
OPENING HEALTH RECORDS 4
TERMINATING HEALTH RECORDS 4
CUSTODY OF HEALTH RECORDS 6
TRANSFER OF HEALTH RECORDS 8
CREATING AN ADDITIONAL VOLUME 9
LOST, DAMAGED, OR DESTROYED HEALTH RECORDS 9
ACCURACY AND COMPLETENESS CHECK 10

SECTION B - HEALTH RECORD FORMS

CG-3443 (HEALTH RECORD COVER) 11
CG-5266 (DRUG SENSITIVITY STICKER) 12
DD2766 (ADULT PREVENTIVE & CHRONIC CARE FLOWSHEET) 12
SF-600 (CHRONOLOGICAL RECORD OF MEDICAL CARE) 13
DD-2808 (REPORT OF MEDICAL EXAMINATION) 15
DD-2807-1 (REPORT OF MEDICAL HISTORY) 21
SF-558 (EMERGENCY CARE AND TREATMENT) 24
DD-2215 (REFERENCE AUDIOGRAM) 26
DD-2216 (HEARING CONSERVATION DATA) 26
AUDIOGRAM RESULTS 26
SF-502 (NARRATIVE SUMMARY) 26
NAVMED 6100/1 (MEDICAL BOARD REPORT COVER SHEET) 26
SF-513 (CONSULTATION SHEET) 27
SF-520 (ELECTROCARDIOGRAPHIC REPORT) 28
SF-515 (TISSUE EXAMINATION) 29
SF-541 (GYNECOLOGIC CYTOLOGY) 29
SF-514 (LABORATORY REPORTS) 29
SF-546-557 (LABORATORY REQUESTS) 29
SF-519 (RADIOGRAPHIC REPORTS) 32
DD-771 (EYEWEAR PRESCRIPTION) 33

SF-601 (IMMUNIZATION RECORD) 35
SF-602 (SYPHILIS RECORD) 35
DD-1141 (RECORD OF OCCUPATIONAL EXPOSURE TO IONIZING RADIATION) 36
CG-4057 (CHRONOLOGICAL RECORD OF SERVICE) 37
NAVMED 6150/2 (SPECIAL DUTY MEDICAL ABSTRACT) 38
PHS-731 (INTERNATIONAL CERTIFICATE OF VACCINATION) 39
CG-5214 (EMERGENCY MEDICAL TREATMENT REPORT) 40
DD-877 (REQUEST FOR MEDICAL/DENTAL RECORDS) 42

SECTION C - DENTAL RECORD FORMS

CG-3443-2 (DENTAL RECORD COVER) 44
NAVMED 6600/3 (DENTAL HEALTH QUESTIONNAIRE) 45
SF-603 (DENTAL RECORD) 45
TYPES OF DENTAL EXAMINATIONS 47
PATIENT CLASSIFICATION DESCRIPTIONS 48
USE OF S.O.A.P. FORMAT IN DENTAL RECORDS 55
SF-603-A (DENTAL CONTINUATION) 59
USE OF SF-513 IN DENTAL RECORDS 60
LOST DENTAL RECORDS 60
SPECIAL DENTAL RECORD ENTRIES 60
DENTAL EXAMINATION REQUIREMENTS 60
RECORDING DENTAL TREATMENTS ON SF-600 61

SECTION D - CLINICAL RECORDS

PURPOSE AND BACKGROUND 62
CONTENTS OF CLINICAL RECORDS 62
EXTRANEOUS ATTACHMENTS 64
OPENING CLINICAL RECORDS 64
TERMINATING CLINICAL RECORDS 64
CUSTODY OF CLINICAL RECORDS 64
SAFEKEEPING OF CLINICAL RECORDS 65
TRANSFER OF CLINICAL RECORDS 65
LOST, DAMAGED, OR DESTROYED CLINICAL RECORDS 66
CLINICAL RECORD FORMS 66

SECTION E - EMPLOYEE MEDICAL FOLDERS

PURPOSE AND BACKGROUND 68
CUSTODY OF EMPLOYEE MEDICAL FOLDERS 68
CONTENTS OF THE EMPLOYEE MEDICAL FOLDERS 69

ACCOUNTABILITY OF DISCLOSURES 70
OPENING EMPLOYEE MEDICAL FOLDER 70
TERMINATING EMPLOYEE MEDICAL FOLDERS 70
TRANSFERRING TO OTHER GOVERNMENT AGENCIES 70
LOST, DAMAGED, OR DESTROYED EMPLOYEE MEDICAL FOLDERS 70
SF-66 D (EMPLOYEE MEDICAL FOLDER) 71

SECTION F - INPATIENT MEDICAL RECORDS

PURPOSE AND BACKGROUND 72
MAINTENANCE AND STORAGE OF INPATIENT MEDICAL RECORDS 73
DISPOSITION OF INPATIENT MEDICAL RECORDS 73
INPATIENT MEDICAL RECORD FORMS AND REQUIRED ENTRIES 75

SECTION G – MENTAL HEALTH RECORDS

ACTIVE DUTY 81
NON –ACTIVE DUTY 81
PSYCHIATRIC EVALUATION FORMAT 81
CUSTODY OF MENTAL HEALTH RECORDS 81

ENCLOSURE (1) MEDICAL/DENTAL RECORD FORMS (.jpegs)

HEALTH RECORD COVER(A/D) (CG 3443) 01
ADULT AND PREVENTIVE AND CHRONIC CARE FLOWSHEET (DD-2766) 02
CHRONOLOGICAL RECORD OF MEDICAL CARE (SF-600) 06
REPORT OF MEDICAL EXAMINATION (DD 2808) 07
REPORT OF MEDICAL HISTORY (DD-2807-1) 10
EMERGENCY CARE AND TREATMENT (SF-558) 13
NARRATIVE SUMMARY (SF-502) 15
CONSULT SHEET (SF-513) 16
ELECTROCARDIOGRAPHIC RECORD (SF-520) 17
TISSUE EXAMINATION (SF-515) 18
GYNECOLOGIC CYTOLOGY (SF-541) 19
LABORATORY REPORTS (SF- 514) 20
RADIOLOGICAL CONSULTATION REQUEST/REPORTS (SF 519) 21
EYEWEAR PRESCRIPTION (DD-771) 22
IMMUNIZATION RECORD (SF-601) 23
SYPHILIS RECORD (SF-602) 25
RECORD OF OCCUPATIONAL EXPOSURE TO IONIZING RADIATION (DD-1141) 27
CHRONOLOGICAL RECORD OF SERVICE (CG4057) 28
SPECIAL DUTY MEDICAL ABSTRACT (NAVMED 6150/2) 30
EMERGENCY MEDICAL TREATMENT REPORT (CG-5214) 32

REQUEST FOR MEDICAL/DENTAL RECORD INFORMATION (DD 877) 33
DENTAL RECORD COVER (CG 3443-2) 34
DENTAL HEALTH QUESTIONNAIRE (CG-5605) 35
DENTAL HEALTH RECORD (SF-608) 36
PERIODONTAL CHART (NAVMED 6660) 38
CLINICAL RECORD COVER (CG 3443-1) 40
REQUEST FOR ANESTHESIA (SF-522) 41
EMPLOYEE MEDICAL FOLDER (SF 66 D) 42
INPATIENT MEDICAL RECORD COVER SHEET 43
MAINTENANCE AND STORAGE CONTAINER DIAGRAM 44
ACCESSION NUMBER DIAGRAM 45
DOCTORS ORDER (SF-508) 47
CLINICAL RECORD PHYSICAL EXAM (SF-506) 48
MEDICAL RECORD PROGRESS NOTES (SF-509) 50
VITAL SIGNS RECORD (SF-511) 51
ABBREVIATED MEDICAL RECORD (DD 2770) 52

CHAPTER 4. HEALTH RECORDS AND FORMS

Section A - Health Records.

1. Purpose and Background.

   a. The health record is the chronological medical and dental record of an individual while a member of the Coast Guard or the Coast Guard Reserve. The primary reasons for compiling a health record are listed below.

      (1) To develop an accurate clinical history that will help in future diagnosis and treatment.

      (2) To protect the Government, the individual concerned, and the individual's dependents. It may be used in adjudicating veterans claims by making permanently available in a single record all entries relative to physical examinations, medical and dental history, preliminary to entry and throughout the individual's entire Coast Guard career. This is accomplished by opening or maintaining medical and dental records:

         (a) upon entry into the Service;

         (b) as required to maintain concise, yet complete, records during period of service; and

         (c) at time of separation.

      (3) To facilitate appraisal of the physical fitness or eligibility for benefits by making the information contained in the health record available to Coast Guard selection boards, disability evaluation system, Board of Correction of Military Records, for income tax purposes, and for claims to the Department of Veterans Affairs.

      (4) To furnish a basis for collecting statistical information.

      (5) To identify deceased persons through dental records when other means are inadequate.

   b. As an individual's service career progresses, the health record increases in value to the Government, the individual, and the individual's family and dependents. Accuracy, therefore, is of the utmost importance in making entries, including entries regarding minor ailments or injuries which appear trivial at the time, but which must be recorded to protect the Government and the individual.

2. Contents of the Health Record.

   a. Each member's health record shall consist of CG-3443 (Health Record Cover) with medical records and dental records arranged as follows:

(1) SECTION I - HISTORY OF CARE. Maintain the Adult Preventive and Chronic Care Flowsheet on top of this Section. All other forms in Section I are to be filed together in reverse chronological order (i.e., most recent on top) in the following sequence. Do not separate corresponding forms DD-2808 and SF-93.

(d) Adult Preventive and Chronic Care Flowsheet Form DD 2766

(e) Consultation Sheet SF-513

(f) Narrative Summary Clinical Resume * SF-502

(g) Report of Medical Examination DD-2802 (Rev. Jul 01), and History and Report of OMSEP Examination Form CG-5447 (Rev.6-00)

(h) Report of Medical History DD2807-1 (Rev. Jul 01)

(i) Report on or Continuation of *, ** SF-507

(j) Medical Board Report Cover Sheet * NAVMED 6100/1

(2) SECTION II - RECORDS OF CARE. All forms in this Section (and their civilian equivalents) are to be filed together in reverse chronological order (i.e., most recent on top) in the following sequence.

(a) Chronological Record of Care SF-600

(b) Emergency Care and Treatment SF-558

(3) SECTION III - RADIOLOGICAL REPORTS. All forms in this Section are to be filed together in reverse chronological order (i.e., most recent on top) in the following sequence.

(a) Radiographic Consultation Request/Report SF-519A

(b) Medical Record-Radiographic Reports SF-519

(4) SECTION IV - LABORATORY REPORTS AND ECG REPORTS. All forms in this Section are to be filed together in reverse chronological order (i.e., most recent on top) in the following bottom to top sequence.

(a) Clinical Record - Laboratory Reports SF-514

(b) Clinical Record - Electrocardiographic Record SF-520

(5) SECTION V - MISCELLANEOUS. All forms in this Section shall be arranged in the following bottom to top sequence.

(a) Chronological Record of Service CG-4057

(b) Special Duty Medical Abstract * NAVMED 6150/2

(c) Record of Occupational Exposure to Ionizing Radiation * DD-1141

(d) Occupational Health Surveillance Questionnaire * CG-5197

(e) Syphilis Record * SF-602

(f) Request for Administration of Anesthesia and for Performance of Operations and other Procedures * SF-522

(g) Hearing Conservation Program microprocessor test result strips taped or stapled to the SF-514 Clinical Record-Laboratory Reports form. DD-2215 Reference Audiogram, and DD-2216 Hearing Conservation Data Sheet, if used, will also be place in section V, in sequential order under the SF 514 "Hearing Conservation Program" form.

(h) Eyewear Prescription DD-771

(i) Immunization Record SF-601

(6) SECTION VI - DENTAL RECORD AND INTERNATIONAL VACCINATION RECORD. All forms in this Section shall be arranged in the following bottom to top sequence.

(a) International Certificate of Vaccination PHS-731

(b) U.S. Coast Guard Dental Record CG-3443-2

1 Sensitivity Sticker * PHS-2410

2 Dental Health Questionnaire CG-5605

3 Health Record - Dental -- (Continuation) * SF-603A

4 Health Record - Dental SF-603

Note:

* --- When required

** -- SF-507's are attached to and filed after the form they continue

*** - Optional Form

b. File forms of the same number in their assigned sequence, with the most recent on top of each previous form, e.g., SF-600 dated 94/02/15 is filed on top of SF-600 dated 94/02/14.

c. Record all dates on the Health Record Cover in the following sequence (all numerals): year/month/day (e.g., 51/02/07).

d. Reports, including laboratory, X-ray, and consultations, shall be reviewed and initialed by the responsible MO, DO, PA/PYA or NP before they are filed in the health record.

e. The health record is a legal document. As such, legibility of all information is essential. Patient ID information shall be typed, printed, or stamped. All entries shall be neat and legible. All signatures shall be accompanied by the stamped or typed name and rank of the practitioner.

3. Opening Health Records.

f. General.

(1) A health record will be opened at the recruiting office for each individual upon entry into the Coast Guard.

(2) A new health record will be opened upon reenlistment of personnel with prior USCG service when such enlistment is not effected the day following discharge. In all cases, request the individual's health record covering prior military service from the National Personnel Records Center, St. Louis, MO.

(3) Other Specific Occasions for Opening Health Record.

OCCASSION	**OPENED BY**
Officer appointed from civilian	First duty station
Reserve Officer	Unit where procured
Cadet	Academy
Retired Personnel recalled to Active Duty	First duty station
Original Record Lost or Destroyed	Responsible Custodian

4. Terminating Health Records.

a. General Instructions.

(1) Upon discharge without immediate reenlistment or enlistment in the Coast Guard Reserve, or retirement, forward the health record (Medical Personnel Data Record or MED PDR) to the servicing PERSRU within 2 days of the member's separation. **DO NOT GIVE THE ORIGINAL HEALTH RECORD TO THE MEMBER UPON FINAL SEPARATION**. Cite the reason for separation on the reverse side of Chronological Record of Service (form CG-4057). The servicing PERSRU shall forward the health record, along with the PERSRU PDR, to Commander (CGPC-adm3) or Commandant (G-RSM-3) for Reservists. (See Section 4-B-27 for additional requirements for

CG-4057.) Health record documents are not filed in the HQ PDR. They will be returned to the unit if received by Commander, (CGPC adm-3) in error.

(2) Discharge for immediate reenlistment at the same unit, revocation of appointment as a temporary officer to continue on active duty in permanent status, or retirement with continuation of active duty are not termination of service.

(3) When a health record is terminated and the dental record is not available for inclusion therein, forward a letter of explanation with the health record.

b. Release from active duty (RELAD) with concurrent transfer to the Coast Guard Reserve or discharge from active duty with immediate enlistment in the Coast Guard Reserve. Upon RELAD, forward the health record (MED PDR) to the servicing PERSRU within 2 days of the member's separation. The servicing PERSRU shall forward the health record, along with the PERSRU PDR, to District (rs) in which the member will reside after separation.

c. Disappearance, Other Than Desertion. Whenever an individual disappears and the facts regarding such disappearance are insufficient to justify a conclusion of death, enter a complete account of the circumstances on an SF-600 in the health record. Do not terminate the health record until final disposition.

d. Desertion.

(4) When an individual is officially declared a deserter, enter an explanatory note on SF-600. Forward the health record (MED PDR) to the servicing PERSRU within 2 days of determination of deserter. The servicing PERSRU shall forward the health record, along with the PERSRU PDR, to Commander (CGPC) or Commander (CGPC-rpm) for Reservists.

(5) Upon return of a deserter to his/her own command, a physical examination shall be performed and recorded on an DD-2808. Retain the original for incorporation into the health record, and forward a copy to Commander (CGPC) or Commander (CGPC-rpm) for Reservists with a request for the deserter's health record.

e. Discharge of Personnel Convicted by Civilian Authorities. When the Commandant directs the discharge of personnel convicted by civilian authorities, the commanding officer will make arrangements for their physical examination, to be recorded on an DD-2808. In the event no medical officer is available, obtain a statement signed by the warden of the penitentiary or reformatory that the person to be discharged from the Coast Guard is physically and mentally qualified for discharge and is not in need of hospitalization. The warden's statement, accompanied by the terminated health record, will be forwarded with the closed out service record.

f. Discharge of Courts-Martial Prisoners Confined in Federal Penitentiaries, Reformatories, and the Naval Disciplinary Command. When the Commandant

directs the discharge of a courts-martial prisoner confined in a Federal penitentiary, reformatory, or the Naval Disciplinary Command, the command to which the prisoner has been administratively assigned shall arrange with the warden for physical examination of the prisoner. Results of this physical examination will be entered on the DD-2808 and signed by the medical officer of the designated penal institution. The command to which the prisoner has been administratively assigned will terminate the health record, using the information furnished on the DD-2808 and the account of medical, dental, and first aid treatments supplied by the penal institution. The terminated health record, DD-2808, and the resume will then be forwarded with the closed out service record.

g. Retired Personnel (Includes Temporary Retirement). Upon notification of retirement, make an entry on CG-4057 under "Remarks" indicating place, date, and category under which retired. The command having custody of the health record will sign the CG-4057 and forward it to the command having administrative control of the member for inclusion in the closed out service record.

h. Cadets. When a cadet's service is terminated, the health record will be terminated and forwarded to the Cadet Record Office, for processing. Following this procedure, the record will be forwarded to the Registrar's Office and held until the departing cadet's class graduates. When this occurs, the record will be forwarded to the Federal Personnel Records Center, St. Louis, MO. This includes cadets who graduate from the Academy but do not accept or are not tendered a commission.

i. Officers (Reserve) to Inactive Duty and Officers (Regular) who Resign to Accept a Reserve Commission. In the case of reserve officers being released to inactive duty and regular officers who resign and accept a commission in the reserve, the health record will be terminated.

j. Death. Upon notification of death, make an entry on CG-4057 under "Remarks" indicating place, time, date, and a short explanation of the circumstances surrounding death. A commissioned officer will sign the CG-4057 and then deliver it and the terminated health record to the commanding officer (no later than the day following death) for inclusion in and transmittal with the member's service record to Commander (CGPC) or Commander(CGPC-rpm).

5. Custody of Health Records.

a. General Responsibilities.

(1) Health records are the property of the Federal government and must be handled in accordance with the provisions of the Privacy Act of 1974 and the Freedom of Information Act. Guidance in this area is contained in the Coast Guard Freedom of Information and Privacy Acts Manual, COMDTINST M5260.3 (series). Health record custody and security requirements are applicable to all documents which contain health information, whether or not filed in the health record, such as Inpatient Medical Records and mental health treatment records.

Disposal of all health record documents shall be in accordance with Coast Guard Paperwork Management Manual, COMDTINST M5212.12(series).

(a) Since health records contain personal information of an extremely critical or sensitive nature, they are considered class III records requiring maximum security (high security locked cabinets or areas).

(b) Except as contained in the Privacy and Freedom of Information Acts Manual, the information contained in health records shall not be disclosed by any means of communication to any person, or to any agency unless requested in writing by or with the prior consent of the individual to whom the record pertains. It is the requestor's responsibility to obtain the consent.

(2) Health records shall be retained in the custody of the Chief, Health Services Division of the unit to which the individual is attached. At units where there is no medical officer attached, the health record will become the responsibility of the executive officer in accordance with Coast Guard Regulations, COMDTINST M5000.3(series), who may delegate custody to the senior health services department representative. At units without a health services technician the custody of the health record is the responsibility of the unit's executive officer. Maintenance of these health records may be delegated to health services personnel of another unit (e.g., groups, support centers, etc.). **At no time shall individual members keep or maintain their own health record**. If there is a need to check out a health record for an appointment at another health care facility, the health record custodian shall have the member complete and sign the health record receipt form (NAVMED 6150/7). The health record custodian shall place the record in an envelope, hand it to the member, and tell the member to return the record as soon as possible following the appointment. The envelope used for record transportation shall bear a printed request reminding outside providers to treat the contents as confidential, and requesting providers to include copies of their consultations or case notes for placement in the health record. The responsibilities contained herein are also applicable to Reserve components.

(3) Individuals may examine their own health record in the presence of a health services department representative, providing:

(a) such examination does not interrupt the unit's scheduled mission, and

(b) there is no information contained therein that would be detrimental to the individual's mental well-being, as determined by the member's attending physician.

(4) Health records are subject to inspection at any time by the commanding officer, executive officer, duly appointed counsel in the case of formal hearings, or duly appointed Coast Guard officials who are conducting authorized

investigations. Such inspections will be conducted in the presence of a health services department representative to aid in the interpretation of information contained in the health record.

(5) Health services personnel making entries in health records shall ensure all entries, including signatures, are neat and legible. Signature information shall include the stamped or printed name and grade or rate of the signer. Facsimile signature stamps may only be used on the PHS-731 and the SF-601.

(6) If an erroneous entry is made in a health record, the author of the entry shall draw a diagonal line through the complete entry, make an additional entry showing wherein and to what extent the original entry is in error, and initial clearly next to the correction.

(7) Health services personnel are responsible for the completeness of the entries made on any medical or dental form while the health record is in their custody. No sheet shall be removed from the health record except under conditions specified in this Manual.

(8) Members are not authorized to write in, alter, remove documents from, or otherwise change their health record or its contents. Request for changes to health record contents shall be made in accordance with procedures contained in Chapter 16 of the Coast Guard Freedom of Information and Privacy Acts Manual, COMDTINST M5260.3.

6. Transfer of Health Records.

a. When active duty or reserve personnel are transferred, The Chief Health Services Division, his designee, the Executive Officer, or the senior Health Services department representative will make the necessary entries in the health record and ensure that the current health record, dental record (SF-603) and Certificate of Vaccination (PHS-731), if applicable, are properly completed.

b. A DD-877 shall be initiated for each record transferred. The DD877 shall be attached to the front cover of the record. The health record will be forwarded to the Coast Guard clinic or Independent Duty Health Services Technician servicing the gaining unit. **Send records using a service that provides a tracking number, such as Priority Mail Delivery Confirmation, Certified Mail, Insured Mail, or FedEx/Express Mail if time is critical.** (See Article 4-D-7.c. of this Manual for policy regarding transfer of Clinical Records of dependents.)

c. Transfer to Federal Penitentiaries, Reformatories, or the Naval Disciplinary Command. A letter of transmittal and a copy of the health record shall accompany a member who is being transferred under sentence of a courts-martial (who has not been or will not be discharged immediately) to a penal institution for execution of the unexpired sentence. The original health record, with a letter of transmittal stating the name of the penal institution to which the prisoner is being transferred and the length of the sentence, shall be forwarded to the command to which the member has been

administratively assigned which shall maintain the health record until the prisoner has been discharged from the Service. A copy of the letter of transmittal shall also be forwarded to Commander (CGPC).

7. Creating an Additional Volume.

   a. Due to chronic medical conditions, long narrative summaries, medical boards, etc., the record may fill to capacity which may cause the loss or damage to new records.

   b. Procedures for creating a second volume:

      (1) Obtain a new Health Record (CG-3443) and transcribe the information from the original jacket.

      (2) Write "VOLUME II" in bold print in the lower left corner of the new jacket cover. Insert forms required by this chapter.

      (3) Write "VOLUME I" in bold print in the lower left corner of the original jacket cover.

      (4) Transfer all documents pertaining to current or chronic illness to the new record.

      (5) Remove the most recent SF-600 from VOLUME I and place it in VOLUME II. Insert a blank SF-600 on top of the remaining forms in VOLUME I and draw a diagonal line across the page. Enter the following on this line:

      CLOSED. NO FURTHER ENTRIES IN THIS RECORD. REFER TO VOLUME II.

      (6) Insert the most recent Report of Medical Examination (DD-2808) and the Report of Medical History (DD-2807-1) into VOLUME II.

      (7) Transcribe the immunization and HIV test date information onto a blank SF-601 and insert it in the appropriate section of VOLUME II.

      (8) Place the original Problem Summary List (NAVMED 6150/20) into VOLUME II and a copy of this form in VOLUME I with the annotation, "CLOSED. NO FURTHER ENTRIES.", below the last entry.

      (9) Place the original Chronological Record of Service (CG 4057) in VOLUME II and a copy in VOLUME I.

8. Lost, Damaged, or Destroyed Health Records.

   a. If a health record is lost or destroyed, a complete new health record shall be opened by the unit health record custodian. The designation "REPLACEMENT" shall be stamped or marked on the cover. If the missing health record should be recovered,

any additional information or entries in the replacement record shall be inserted in the old record.

b. Health records which become illegible, thus destroying their value as permanent records, shall be restored and duplicated. The duplicate shall, as nearly as possible, be an exact copy of the original record before such record becomes illegible. Take particular care in transcribing the date on DD-2808 into the new record as such information may be required by the Department of Veterans Affairs to determine the individual's right to pension or other Federal benefits. Stamp or mark "DUPLICATE" on the cover of the new record. Explain the circumstances necessitating the duplication on an SF-600. Forward health records replaced by duplicate records to CGPC-adm-3.

9. Accuracy and Completeness Check.

a. Upon transfer of an individual, the health record custodian at both the detaching unit and the receiving unit shall inspect the health record for accuracy and completeness, in accordance with the following guidelines:

(1) that all immunizations are up-to-date (See Immunizations and Chemoprophylaxis, COMDTINST 6230.4 (series));

(2) that PPD screening is current in accordance with Section 7-D of this Manual;

(3) that all required audiograms are completed, especially on personnel involved in the hearing conservation program;

(4) that required forms have been properly completed and are in the correct order;

(5) that all deficiencies in physical requirements shall be scheduled for correction, all missing forms shall be replaced, and all other clerical or administrative errors corrected; and

(6) that all OMSEP requirements are met.

b. The health record custodian shall ensure that all identified deficiencies are corrected immediately. Appointments shall be scheduled and the individual's supervisor notified of the need to correct deficiencies as soon as possible.

c. Upon separation of the individual from the Service, the unit terminating the health record will inspect the health record, correct all errors, fill in omissions, and make sure the patient identification information is completed on all forms.

Section B - Health Record Forms.

1. **CG-3443 (Health Record Cover).** See Encl (1), pg.4-1. Each patient's health record shall be maintained in a CG-3443 (Health Record Cover). The CG-3443 shall be completed according to the following instructions:

   a. Last Name. Record in all capital letters.

   b. Given Name(s). Record given name(s) in full without abbreviations. If the individual has no middle name or initial then use the lower case letter "n" in parentheses (n). If the individual has only a middle initial(s) record each initial in quotation marks. When "Jr." or "II" or other similar designations are used they shall appear after the middle name or initial.

DOE	**John**	**Buck**	**Jr**.
Surname	**First Name**	**Middle Name**	

   c. Beneficiary. Enter the appropriate beneficiary code to describe the patient (enter "20" for active duty members).

      (1) 01 to 19 - Dependent children in order of birth

      (2) 20 - Sponsor

      (3) 30 - Spouse

      (4) 31-39 - Unremarried former spouse

      (5) 40 - Dependent mother (active duty)

      (6) 45 - Dependent father (active duty)

      (7) 50 - Dependent mother-in-law (active duty)

      (8) 55 - Dependent father-in-law (active duty)

      (9) 60 - Other dependents

      (10) 80 - Humanitarian (non-eligible)

      (11) 90 - Civilian employee

      (12) 99 - Other eligible

   d. Sponsor's Social Security Number. Enter.

   e. Blood Type and Rh Factor. Enter the blood-type and Rh factor in the appropriate boxes. Use utmost caution when recording this information. If not known, complete a blood-type and Rh factor test as required.

f. Special Status. Check the appropriate block to indicate whether the individual is in aviation or diving status, has a waiver, requires occupational monitoring, or has an allergy.

g. Date of Birth. Enter year, month and day (e.g., 51/02/07).

h. Local Use. Use the spaces provided below the sensitivity sticker location for local use information such as rank, unit, etc. as needed.

2. CG-5266 (Drug Sensitivity Sticker).

a. General. Form CG-5266 should be initiated for anyone having documented history of sensitivity or hypersensitivity to specific drugs, serums, or vaccines, including PPD converters. Other non-drug allergies should be indicated on this form only if they will affect potential therapy (e.g., egg yolks). Every effort shall be made to verify the reported sensitivity and to confirm that it is allergic in nature.

b. Detailed Instructions.

(1) Prepare two originals. (One each for the health and dental records.)

(2) List the name of each drug, serum, vaccine, or anesthetic indicated on the DD-2766 Adult Preventive and Chronic Care Flowsheet.

(3) Affix the CG-5266 vertically to the indicated location on the health record cover (form CG-3443) and vertically to the lower left corner on the front of the dental record cover (CG-3443-2).

3. **DD2766 (Adult Preventive and Chronic Care Flowsheet Form).** See Encl (1), pg 4-2.

a. General. The Adult Preventive and Chronic Care Flowsheet Form documents significant/chronic health problems, allergies, chronic medications, hospitalizations/surgeries, health counseling, immunizations, PPD, DNA & HIV testing, screening (preventive medicine) exams, other medical readiness items (such as blood type, G6PD, sickle cell, glasses, dental exam, etc), and chart audits. In-house training sessions should be conducted prior to the implementation of this form.

b. Detailed Instructions. DD2276 should be inserted as the first page of the medical record and all sections completed by the health care provider with the following guidelines exceptions:

(1) Information from previous Problem Summary Lists should be copied and updated onto the DD2276 as it is placed in the health record.

(2) If the patient is not allergic to any drugs, indicate NKDA (no known drug allergies), in block 1.a.

(3) Sections 8.a., 10.e. and 10.i. are not required to be completed.

(4) Use a pencil to darken the circles on Section 7, Screening Exam.

(5) The medical officer should enter the date and location of every deployment the member participates in Section11, Pre/Post Deployment History. Pre and post deployment questionnaires are documented in Section 11 for participants in DOD deployment.

4. **SF-600 (Chronological Record of Medical Care)**. See Encl (1), pg 4-6.

a. General.

(1) This form provides a current, concise, and comprehensive record of a member's medical history. Properly maintained, the SF-600 should: aid in evaluating a patient's physical condition; greatly reduce correspondence to obtain medical records; eliminate unnecessary repetition of expensive diagnostic procedures; and serve as an invaluable permanent record of health care received. The SF-600 shall be continuous and include the following information as indicated: complaints; duration of illness or injury, physical findings, clinical course, results of special examinations; treatment; physical fitness at time of disposition; and disposition. The SF-600 also serves as the patient's prescription from which pharmacy services are provided.

(2) When a new SF-600 is initiated, complete the identification block with the name (last, first, middle initial), sex (M or F), year of birth, component (active duty or reserve), service (USCG, USN, USA, etc.), Social Security Number, and the member's grade/rate and organization at the time the form is completed.

(3) File SF-600's on the right side of the medical record with the most current SF-600 on top.

(4) Enter sick call entries on SF-600 in the following SOAP format

SOAP METHOD OF SICK CALL WRITE UPS

S: (Subjective).

cc: (Chief Complaint) sore throat, cough, diarrhea, etc.

hpi: (History Present Illness) onset of symptoms, all problems, review of symptoms

pmh: Past Medical History) any related problems in past that may be present with chief complaint

fh: (Family History) any diseases, chronic/acute, possibly related to present complaint

all: (Allergies) any known allergies to drugs/medications, etc.

0: (Objective).

First visual assessment/evaluation of the patient's general appearance: limping, bleeding, doubled over, etc.

PE: All results of physical exam, vital signs, lab, x-ray, and any other study results

A: (Assessment).

Imp: (Impression, Diagnosis) includes R/0 (rule out)

NOTE: THIS IS TO INCLUDE, AFTER IMPRESSION, WHAT YOU ARE GOING TO DO NOW AND WHY--SUCH AS, SUTURING, TOURNIQUET, ETC.

P: (Plan).

List of medications given, lab, x-ray, special studies ordered, duty status, return appointments, referrals, etc.

(5) The entries for all treatments shall be complete with regard to place, date, problem number (if appropriate), number of sick days, diagnosis of all conditions for which treated and signature of individual furnishing treatment. Note all facts concerning the origin of the disease, pregnancy status, symptoms, course, treatment, and if a conflicting opinion is expressed subsequently by the same, or another medical officer, fully state the reason for such change. The record need not be voluminous, but it shall be thorough, concise, clearly phrased, and complete in each case. All entries, including signatures, must be legible.

(6) When a member is injured or contracts a disease while on leave, or when for any other reason the facts concerning an injury or sickness have not been entered in the individual's health record, the record custodian shall ascertain the facts in the case and make the necessary entries on SF-600. Discuss and document the instructions given to the patient. Include the intended treatment and, as appropriate, possible alternative treatments, possible complications, and long term prognosis. Information regarding previous treatments should be entered giving the following: date, place, and full details of treatment; laboratory reports; x-ray results; etc. The following shall also be entered:

(7) "Date:
"Transcribed From Official Records.

Signature/Rate Duty Station of Transcriber"

(8) When an individual is required to carry the PHS-731, enter a statement of acknowledgment on the SF-600.

(9) When an individual is diagnosed as having a Sexually Transmitted Disease (STD) make an entry to record that an interview was conducted and that the following was discussed with the patient:

(a) symptoms,

(b) complications,

(c) treatments, and contacts.

5. Treatment at Other Than Unit Assigned. When an activity furnishes sick call treatment to an individual whose health record is not available, an entry shall be made on a new SF-600 and forwarded to the individual's duty station for inclusion in the health record.

6. **DD-2808 (Rev. Jul 01) (Report of Medical Examination).** See Encl (1), pg. 4-7.

a. Purpose. The DD 2808 (Rev: Jul 2001) is used to record physical examination results to determine whether an examinee does, or does not, meet the standards established for the type of physical examination administered (i.e., initial enlistment, officer programs, retention, release from active duty, diving, aviation, retirement, etc.). The SF-88 is no longer applicable.

b. Preparation.

(1) When Prepared. DD-2808 shall be prepared and submitted to the reviewing authority whenever a complete physical examination is required.

(2) Required Entries. Certain groups of personnel are required to meet physical standards somewhat different from other groups. Accordingly, the use of all the spaces or use of the same spaces on the DD-2808 is not necessarily required for reporting the results of the various categories of physical examinations. If a certain item of the medical examination is required and facilities for accomplishing it are not available, an entry **"NFA"** (No Facilities Available) shall be made in the appropriate space. An entry **"NE"** (Not Evaluated) shall be made in the appropriate space for any item of the clinical evaluation (Items 17-42) which was not evaluated. For other items listed on the DD-2808 which were not required for a particular category of physical examination, an entry **"NI"** (Not Indicated) shall be made in the appropriate space. Reference should be made to other provisions of Chapter 3, which prescribe the nature and scope of each physical examination and indicate the applicability of items of the DD-2808 to the particular program. Unless otherwise indicated by such provisions, the minimum requirements for completing the DD-2808 are:

(a) All Examinations. Items 1-44, 45-63, 66, and 71a, shall be completed for all physical examinations, if facilities are available. Item 41, shall be completed for all female personnel.

(b) Aviation Personnel. Additionally, Items 64,65, and 66-70 and 72b shall be completed for physical examinations of aviation personnel.

(3) A physical examination must be thorough, recorded accurately, and contain sufficient information to substantiate the final recommendation. Before signing and forwarding, the examiner shall review the completed DD-2808 for completeness and accuracy. Failure to do so reflects significantly on the examiner's clinical and/or administrative attention to detail. Remember that the reviewing authority does not have the advantage of a direct examination and must rely on the examiner's written record and appropriate additional information in arriving at a decision.

c. Details for Entries on DD-2808.

(1) **Item 1**: **Date of Examination**. Enter date in format - 02Aug15.

(2) **Item 2: Social Security Number**. Enter the nine digits of their SSN.

(3) **Item 3: Last Name.** Last Name - First Name - Middle Name. Record the surname in all capital letters. Record the given name(s) in full without abbreviation. If the individual's first or middle name consists only of an initial, enclose each initial in quotation marks (i.e., MANUEL, Thomas "W"). If the individual has no middle name, enter the letter "(n)" in parenthesis [i.e., TARVIN, Laurie (n)]. Designations, such as, "Jr." or "II" shall appear after the middle name or initial. In the absence of a middle name or initial, these designations shall appear after the "(n)."

(4) **Item 4: Home Address.** Enter the evaluee's present residence and not the home of record.

(5) **Item 5: Home Telephone Number.** NA

(6) **Item 6: Grade**. Use official abbreviation of the current grade or rate. Example: HSCS; LTJG. If not a service member, enter "civilian."

(7) **Item 7: Date of Birth**. (e.g.57Sep04).

(8) **Item 8: Age**. Enter age.

(9) **Item 9: Sex**. Mark one or the other of the boxes.

(10) **Item 10: Race**. Mark the box next to the racial or ethnic group of which member belongs.

(11) **Item 11: Total Years of Government Service.** Enter years and months (e.g., 06 yrs 04 mo's).

(12) **Item 12: Agency**. Enter the OPFAC number of the unit to which the examinee is attached.

(13) **Item 13: Organization and UIC/Code.** List name of ship or station to which the examinee is assigned. Initial entry into Service; enter recruiting office concerned.

(14) **Item 14a: Rating or Specialty**. NA

(15) **Item 14b: Total Flying Time.** Aviators only or NA.

(16) **Item 14c: Last six months.** Aviators only or NA.

(17) **Item 15a**: **Service**. Mark a box next to appropriate service.

(18) **Item 15b: Component.** Mark a box next to appropriate component.

(19) **Item 15c: Purpose of Examination**. Mark the box and corresponds to the appropriate purpose(s) of the examination. If not listed, mark "Other," and explain above the box such as: Diving Applicant; Biennial Aircrew; etc. For a medical board, indicate whether it is an IMB (Initial Medical Board)/DMB (Disposition Medical Board), etc. Do not use the incomplete terms "flight physical," "diving physical," or "aviation physical." Rather, use specific terms such as "Class I Aviation," "Candidate for Flight Training," "Class II Aircrew," "Dive Candidate," "Quinquennial Diving," etc. Avoid nonstandard abbreviations. Differentiate between an applicant for a special program and a biennial physical for the same program. When necessary, continue under Item 73, Notes.

(20) **Item 16: Examining Facility or Examiner.** For civilian or contract physician, enter the full name and address. For USMTF, enter only the facility name, city and state in which located.

(21) **Item 17-42: Clinical Evaluation**. Check each item in appropriate column.

(a) **Item 35:** Is continued on lower right side (Feet), circle appropriate category.

(22) **Item 43: Dental Defects and Disease.** For an oral examination as part of an accession physical, record whether or not the applicant is 'Acceptable' or 'Not Acceptable'. Refer to the standards described in Chapter 3 Section D-5 Physical standards for enlistment, appointment, and induction. Enter disqualifying defects in detail in Item 73. Record the Dental Classification. Refer to Chapter 4 Section C-3-c for definitions of dental classes. For routine physical examinations, record only the Dental Classification. When oral disease or dental defects are discovered on examination of active duty member personnel, suitable recommendations will be made for instituting corrective

measures. A copy of form SF-603, Dental Record does not need to be attached to the DD-2808.

(23) **Item 44: Notes.** Describe every abnormality from Items 17-43 in detail. Enter pertinent item number before each comment**.** Continue in Item 73 and use Continuation Sheet (SF-507), if necessary.

(24) **Item 45: Laboratory Findings.** Enter all laboratory results in quantitative values.

(a) **Urinalysis**. Enter specific gravity and results of albumin, sugar and if required, microscopic tests in the indicated spaces.

(b) **Item 46: Urine HCG.** If applicable.

(c) **Item 47: H/H**. Enter either the hematocrit or the hemoglobin results.

(d) **Item 48: Blood Type.** If applicable.

(e) **Item 49: HIV**. Enter date drawn only in the results section.

(f) **Item 50: Drugs Test Specimen ID Label**. NA

(g) **Item 51: Alcohol**. NA

(h) **Item 52: Other**. Enter all other tests performed and their results which are not indicated on the form and which were performed in connection with the physical examination (e.g., sickle cell test, PAP test, PPD, EKG, Chest X-ray results, etc.). The results will be continued in Item 73 or on Continuation Sheet (SF 507), if necessary. If provided on the lab report, include "normal" range values for all tests performed by a civilian or military lab. Use quantitative values and avoid vague terms such as "WNL" or other such qualitative forms.

(25) **Item 53: Height**. Measure without shoes and record to the nearest one-half centimeter ((one-half inch)

(26) **Item 54: Weight**. Measure with the evaluee in under garments and record results to the nearest kilogram (pound).

(27) **Item 55: Min Weight-Max weight, Max BF%**. NA

(28) **Item 56: Temperature**. Leave Blank.

(29) **Item 57: Pulse**. Record the actual pulse rate.

(30) **Item 58: Blood Pressure**. Record the actual value in numerals for both systolic and diastolic.

(31) **Item 59: Red/Green**. NA

(32) **Item 60: Other Vision Test**. If applicable.

(33) **Item 61: Distant Vision.** Test and record using the Snellen scale. Record vision in the form of a fraction and in round numbers, that is 20/20, 20/40, not 20/20-2 or 20/40-3.

(34) **Item 62: Refraction**. Enter the lens prescription when the evaluee wears (or requires) lenses for correction of visual acuity. Do not enter the term "lenses."

(35) **Item 63: Near Vision.** Test and record using the Snellen scale. (See item 61).

(36) **Item 64: Heterophoria**. Enter when indicated.

(37) **Item 65: Accommodation**. Enter when indicated.

(38) **Item 66: Color Vision.** Color Vision. Enter the test used and the results.

(a) Farnsworth Lantern. Record the results as "Passed FALANT" or "Failed FALANT" followed by the fraction of correct over total (i.e., 9/9 or 17/18).

(b) Pseudoisochromatic Plates (PIP). Record results as "Passed PIP" or "Failed PIP" followed by the fraction of correct over total (i.e., 12/14 or 14/14).

(c) Enter "Passed on record" or "failed on record" if the results of a previous PIP or FALANT examination are available on record for review.

(39) **Item 67: Depth Perception**. When indicated, enter test used in left portion of Item 67.

(a) AFVT. In the appropriate space in the right-hand portion of Item 65, record the letter designation of the highest group passed (i.e., Passed F).

(b) Verhoeff. In the appropriate space in right-hand portion of Item 34, record perfect score as 16/16.

(40) **Item 68: Field of Vision**. Enter when indicated.

(41) **Item 69: Night Vision**. Enter when indicated.

(42) **Item 70: Intraocular Tension**. When indicated, enter the results in millimeters of mercury.

(43) **Item 71: Audiometer**. Required on ALL physical examinations. Use ANSI 1969 standards, do not use ISO or ASA standards.

(a) **Item 71a**: Current

(b) **Item 71b:** If **applicable**.

(44) **Item 72a:** **Reading Aloud Test**. If applicable.

(45) **Item 72b:** **Valsalva.** When indicated mark either SAT or UNSAT.

(46) **Item 73:** **Notes and Significant or Interval History**. Use this space for recording items such as:

(a) any pertinent medical history;

(b) summary of any condition which is likely to recur or cause more than minimal loss of duty time;

(c) wrist measurements;

(d) most recent HIV antibody test date (see Article 3-C-20.b.(5) of this Manual);

(e) date of PPD and results; and

(f) Preventive Medicine stamp per Use of Preventive Medicine Stamp, COMDTINST 6200.11(series), for exams originating in Coast Guard sickbays and clinics.

(47) **Item 74a:** **Examinee's Qualification.** State whether or not the examinee is qualified for the purpose of the examination. If the purpose for the examination is an IMB or DMB, state whether or not the examinee is qualified or not qualified for retention and to perform the duties of his/her rank/rate at sea and foreign shores.

(48) **Item 74b:** **Physical profile.** Leave blank.

(49) **Item 75:** **I have been advised of my disqualifying condition**. If indicated, have evaluee sign and date.

(50) **Item 76:** **Significant or Disqualifying Defects**. Leave Blank

(51) **Item 77:** **Summary of Defects and Diagnoses.** List ALL defects in order to protect both the Government, and evaluee, in the event of future disability compensation claims. All defects listed which are not considered disqualifying shall be so indicated by the abbreviation NCD (Not Considered Disqualifying). When an individual has a disease or other physical condition that, although not disqualifying, requires medical or dental treatment clearly state the nature of the condition and the need for treatment. If a medical or dental condition is disqualifying, and treatment is scheduled to be completed prior to transfer to overseas or sea duty, indicate the date the member is expected to be fully

qualified, e.g., "Dental appointment(s) scheduled, patient will be class I (dentally qualified) by (date)**". Leave Profile Serial, RBJ, Qualified, and Waiver blocks blank.**

(52) **Item 78: Recommendations**. Indicate any medical or dental recommendations. Specify the particular type of further medical or dental specialist examination indicated (use SF-507, if necessary).

(53) **Item 79: MEPS Workload.** Leave Blank.

(54) **Item 80: Medical Inspection Date**. Leave Blank.

(55) **Item 81-84: Names and Signature of Examiners**. The name, grade, branch of Service, and status of each medical and dental examiner shall be typewritten, printed, or stamped in the left section. Each examiner shall sign using ballpoint pen or ink pen (black or blue-black ink only) in the appropriate section. Do not use facsimile signature stamps. When attachment sheets are used as a supplement or continuation to the report, they shall be serially number (both sides); however, indicate only the actual number of attached sheets in the bottom right **block 87** on DD-2808.

(56) **Item 85: Administrative Review**. The person who reviews the PE prior to submitting for approval shall sign and date.

(57) **Item 86: Waiver Granted.** Leave Blank.

(58) **Item 87: Number of attached Sheets**. Fill in with appropriate number of forms attached.

7. **DD-2807-1 (Rev. Jul 01) (Report of Medical History)**. See Encl (1), pg. 4-7.

a. Purpose. DD-2807-1 provides a standardized report of the examinee's medical history to help the examiner evaluate the individual's total physical condition, and to establish the presence of potentially disabling conditions which are not immediately apparent upon physical examination. In preparing the form, encourage the examinee to enter all medical problems or conditions experienced, no matter how minor they may be. The examiner must investigate and evaluate all positive medical history indicated on the form.

b. Preparation and Submission of DD-2807-1. Prepare and submit DD-2807-1 with all physical examinations except: Periodic OMSEP and Substitution/Overseas/Sea Duty Modified Physical Examination.

c. Preparation Procedures. DD-2807-1 shall be prepared by the examinee and the examining medical officer.

(1) The examinee shall furnish a true account of all injuries, illnesses, operations, and treatments since birth. False statements or willful omissions in completing

the DD-2807-1 may result in separation from the Service upon arrival at the Academy, Recruit Training Center, Officer Candidate School, or later in the individual's career.

(2) A copy of the DD-2807-1 must be included in the member's health record. Entries must be printed, in the examinee's and examiner's own handwriting, using either ball-point pen or ink pen (black or dark blue). Pencils or felt-tip pens will not be used. Information in the numbered blocks on the form will be entered in the following manner:

(a) **Item 1: Last Name, First, Middle Name**. SMITH, Hannibell H. Record the surname in all capital letters. Record the given name(s) in full, without abbreviation. If the individual's first or middle name consists only of an initial, enclose each initial within quotation marks. If the individual has no middle name, enter the letter "(n)" in parenthesis. Designations such as "Jr." or "II" will appear after the middle name or initial or after "(n)" if there is no middle name.

(b) **Item 2: Social Security Number**. Enter SSN.

(c) **Item 3: Enter date format** –2001Sep04.

(d) **Item 4a: Home Address.** Enter the evaluee's present residence and not the home of record.

(e) **Item 4b: Home Telephone.** Enter home phone number.

(f) **Item 5: Examining Location and Address.** For civilian or contract physician, enter the full name and address. For a USMTF, enter only the facility name and the city and state in which located.

(g) **Item 6a: Service.** Mark a box next to the appropriate service.

(h) **Item 6b: Component**. Mark a box next to the appropriate component.

(i) **Item 6c**: **Purpose of Examination**. Mark a box next to the appropriate purpose(s) of the examination. If not listed, mark “Other” and explain above the box such as: Diving Applicant; Biennial Aircrew; etc. For a medical board, indicate whether it is an IMB (Initial Medical Board)/DMB (Disposition Medical Board), etc. Do not use the incomplete terms “flight physical,” “diving physical,” or “aviation physical.” Avoid nonstandard abbreviations. Differentiate between an applicant for a special program and a biennial physical for the same program.

(j) **Item 7a: Position.** Use official abbreviation of current grade or rate, branch of the Service, class and status; i.e., regular, reserve, or retired and if active or inactive. Example: HSCM, USCG; LTJG, USCGR;

HSC, USCG (RET); HS3, USCG (TEMPRET). If not a Service member, enter "civilian."

(k) **Item 7b: Usual Occupation**. List current occupation.

(l) **Item 8: Current Medications.** List all current medications including over the counter meds.

(m) **Item 9: Allergies**. List any allergies to insect bites/stings, foods medicine or other substances.

(n) **Item 10 to 28**. Check appropriate box.

(o) **Item 29: Explanation of "Yes" Answer(s).** Describe all "yes" answers from section 10-28. Include date(s) of problems, name of doctor(s), and /or hospitals(s), treatment given and current medical status.

1 Append Item 29 to include: The statement to present health and a list of medications presently being taken by the examinee. For individuals receiving examinations more frequently than quinquennial, there is often little change in the medical history from year to year. As an alternative to having the examinee complete Section 10-28 of the DD-2807-1 at a periodic examination, the following statement may be entered in Item 29 and initialed by the person undergoing the examination.
"I have reviewed my previous Report of Medical History and there have been no changes since my last medical examination, except as noted below." _____(initials)

(p) **Item 30. Examiner's Summary and Elaboration of all Pertinent Data.** Prior to performing the physical examination, the examiner will review the completeness of the information furnished on the DD-2807-1. When this is done, summarize the medical history under (**Item 30a. Comments)** as outlined below and then sign the form. If additional space is needed, use Continuation Sheet, SF-507.

(q) Do not use the term "usual childhood illnesses"; however, childhood illnesses (those occurring before age 12) may be grouped together enumerating each one. Incidents, other than those occurring in childhood, shall have the date recorded rather than the examinee's age. Do not use "NS" or "non-symptomatic" for items of history. Use "NCNS," "No Comp., No Seq." after items of recorded history where applicable. Elaborate on all items of history answered affirmatively except "Do you have vision in both eyes". The following specific questions shall also be asked on examination for initial entry into the Coast Guard, and for aviation and diving duty applicants:

1 "Is there a history of diabetes in your family (parent, sibling, or more than one grandparent)?"

2 "Is there a history of psychosis in your family (parent or sibling)?"

3 "Do you now or have you ever worn contact lenses?"

4 "Do you now or have you ever used or experimented with any drug, other than as prescribed by a physician (to include LSD, marijuana, hashish, narcotics, or other dangerous drugs as determined by the Attorney General of the United States)?"

5 "Have you ever required the use of an orthodontic appliance attached to your teeth or a retainer appliance? Month and year last worn? Are they still necessary?"

6 "Are there any other items of medical or surgical history that you have not mentioned?" All affirmative answers to the above questions shall be fully elaborated in Item 25. Negative replies to the above questions shall be summarized as follows: "Examinee denies history of psychosis, use of drugs, history of wearing of contact lenses, requirement for any orthodontic appliance, all other significant medical or surgical history; family history of diabetes." A rubber stamp or the overprinting of this information in Item 25 is recommended.

(3) Distribution. Attach the original DD-2807-1 to the original DD-2808 and submit to reviewing authority. A copy of the DD-2807-1 and DD-2808 shall be kept on file at the unit pending the return of the approved DD-2807-1 and DD-2808.. After review and endorsement, the reviewing authority shall forward the original DD-2807-1 and DD-2808 to the members parent command for insertion into the members health record.

8. **SF-558 (Emergency Care and Treatment) (Rev 9-96).** See Encl (1), pg. 4-13. This form provides a comprehensive yet concise record of emergency health care. It shall be used whenever an individual receives emergency treatment. Detailed instructions for completing the form are as follows:

a. Patient's Home Address or Duty Station. Complete all blocks in this section.

b. Arrival. Record the date and time the patient arrived at the clinic or emergency room for care.

c. Transportation to Facility. Record the name of the ambulance company or unit that transported the patient for care, if appropriate. If patient was not transported by ambulance or other emergency vehicle, enter "N/A'.

d. Third Party Insurance. List detailed insurance if known by patient. If potential third party liability exists, forward a copy of SF-558 to Commandant (G-WRP-2). Note: Disregard DD2568 in chart, enter N/A).

e. Current Medications. List all medications patient is presently taking.

f. Allergies. Record any substance or drug to which the patient has a known or suspected allergy. If none, enter "NKA" (No Known Allergy).

g. Injury or Occupational Illness. Most fields. When, refers to date injury was sustained. Where, refers to location injury occurred. How, refers to what happened (briefly).

h. Emergency Room Visit. Self-Explanatory.

i. Date of Last Tetanus Shot. Self-Explanatory.

j. Chief Complaint. Record a brief description of why the patient is seeking health care.

k. Category of Treatment. If Condition is Result of Accident/Injury. Check the block that best describes the patients' condition upon arrival.

(1) Emergent. A condition which requires immediate medical attention and for which delay is harmful to the patient; such a disorder is acute and potentially threatens life or function.

(2) Urgent. A condition which requires medical attention within a few hours or danger can ensue; such a disorder is acute but not necessarily severe.

(3) Non-Urgent. A condition which does not require the immediate resources of an emergency medical services system; such a disorder is minor or non-acute

l. Vital Signs. Take and record all vital signs. Indicate the time vitals were taken. Use 24-hour clock annotation i.e. 0215.

m. Lab Orders and X-Ray Orders. Self-Explanatory, check appropriate box.

n. Orders. List orders given by provider. Record all medications, appointments made. Or any other follow-up plans.

o. Disposition. Check appropriate box. Ensure patient understands this section.

p. Patient/Discharge Instructions. Be specific. Ensure patient understands instructions given.

q. Patients Signature and Date. Have the patient or person accompanying the patient sign the form. This signature only acknowledges that instructions were given to the patient.

r. Time Seen by Provider. Record the time when the patient received treatment. Use 24-hour clock annotation i.e. 0215.

s. Test Results. Record results of tests ordered on patient.

t. Provider History/Physical. Self-explanatory, use standard S.O.A.P. format.

u. Consult With. List all individuals that on-scene provider received medical advice from. Example Dr. Richard Smith.

v. Diagnosis. Record patient diagnosis.

w. Providers Signature and Date. The medical officer or other health care provider shall sign and date the form.

x. Codes. List all ICD-9 codes applicable to the patient.

y. Patients' Identification. Ensure all patient identification information is entered.

9. DD-2215 Reference Audiogram. Optional. Place form in section V of the Health Record.

10. DD-2216 Hearing Conservation Data. Optional. Place form in section V of the Health Record.

11. Audiogram Results. The Microprocessor will generate a legal archival test result strip, which shall be fastened to a separate SF-514, Clinical Record-Laboratory report form, dedicated to this purpose and filed under section V of the Health Record. Label this SF-514 "Hearing Conservation Program" across the bottom.

    a. All test result strips shall be placed sequentially onto form SF-514 in left to right formation overlapping 2/3 of the last audiogram.

12. **SF-502 (Narrative Summary).** See Encl (1), pg.4-15. SF-502's are used for a variety of purposes, such as:

    a. to summarize the important facts about a patient's hospitalization;

    b. to summarize the findings of a medical board; or

    c. to report the results of a Board of Flight Surgeons.

    If received subsequent to the individual's discharge from the hospital, it shall be inserted in the health record immediately upon receipt.

13. NAVMED 6100/1 (Medical Board Report Cover Sheet).

a. The NAVMED 6100/1 is used in preparing a medical board. A copy of the NAVMED 6100/1 and the complete medical board shall be inserted into the individual's health record.

b. Detailed instructions for preparing and distributing this form are contained in Physical Disability Evaluation System, COMDTINST M1850.2 (series).

14. **SF-513 (Consultation Sheet).** See Encl (1), pg 4-16.

a. Purpose. SF-513 is used whenever a patient is referred to another facility for evaluation.

b. Detailed Instructions. Complete the form as follows:

(1) To. Facility or department to which the patient is being referred.

(2) From. Unit referring the patient.

(3) Date of Request. Self-explanatory.

(4) Reason for Request. Specify the reason for referring the patient, i.e., chest pains, infected sebaceous cyst, etc.

(5) Provisional Diagnosis. Self-explanatory.

(6) Doctor's Signature. Must be signed by a medical officer, dental officer, or health services department representative. Accompanying this signature should be the qualifying degree of the individual requesting the consult.

(7) Approved. Leave Blank.

(8) Place of Consultation. Check the appropriate block.

(9) Emergency/Routine. Check the appropriate block.

(10) Identification No. Enter the patient's SSN.

(11) Organization. Enter patient's branch of service.

(12) Register No. If inpatient, enter the appropriate register number. If outpatient, leave blank.

(13) Ward No. If outpatient enter "OP." If inpatient, enter appropriate ward number.

(14) Patient's Identification. Enter the appropriate patient identification information.

(15) The remainder of the form is completed by the consultant.

c. When the consultation sheet (SF-513) is completed and returned by the consultant, the following actions are required:

(1) Originator shall review and sign the SF-513;

(2) Originator shall complete a Visit Profile sheet (CG-5460B) as directed by Use of Clinic Automated Management System (CLAMS), COMDTINST 6010.18(series) for later entry into CLAMS; and

(3) The SF-513 shall then be filed in the appropriate dental or medical section of the health record.

15. **SF-520 (Electrocardiographic Report).** See Encl (1), pg.4-17.

a. Purpose. SF-520 is used to report the results of all electrocardiograms.

b. Detailed Instructions. The individual performing the electrocardiogram shall complete the form as follows:

(1) Previous ECG. Check appropriate block

(2) Clinical Impression. Reason why the electrocardiogram was requested, e.g., chest pain, physical examination, etc.

(3) Medication. Enter any medications that the patient is taking.

(4) Emergency/Routine. Check appropriate block.

(5) Bedside/Ambulant. Check appropriate block.

(6) Age. Enter patient's age as of last birthday.

(7) Sex. Enter "M" or "F," as appropriate.

(8) Race. Leave blank.

(9) Height. Enter to nearest one-half centimeter (one-half inch).

(10) Weight. Enter to the nearest kilogram (pound).

(11) B.P. Enter recumbent blood pressure.

(12) Signature of Ward Physician. Signature of medical officer ordering the electrocardiogram.

(13) Date. Date the ECG was performed using appropriate format.

(14) Register No. Enter patient's social security number.

(15) Ward No. Enter "OP" (outpatient) or appropriate ward no.

(16) Patient's Identification. Enter the appropriate patient identification information.

(17) The remainder of the form is completed by the medical officer evaluating the electrocardiogram.

c. The baseline ECG shall be appropriately marked "Baseline ECG."

16. **SF-515 (Tissue Examination).** See Encl (1), pg.4-18.

a. Prepare a SF-515 whenever a tissue specimen is forwarded to a laboratory for examination.

b. Ensure patient's identification information is completed.

17. **SF-541 (Gynecologic Cytology).** See Encl (1), pg.4-19.

a. Prepare a SF-541 whenever a vaginal or cervical smear (PAP test) is forwarded to a laboratory for examination.

b. Ensure patient's identification information is completed.

18. **SF-514 (Laboratory Reports).** See Encl (1), pg.4-20.

a. This is a display form for mounting graphic reports, automated printout reports, or printed reports associated with special equipment.

b. Attach the laboratory reports to the indicated spaces with the most recent on top.

c. Ensure patient's identification information is completed.

d. Clinical Record - Laboratory Report Display (SF-545). May be used in lieu of SF-514. This is a display form for mounting laboratory requests and report forms. When a patient will require the same type of test several times, a separate display sheet shall be used for each type of test. In low use situations, the various test result forms should be mounted on alternate strips 1, 3, 5, and 7.

(1) The following Standard Forms should be mounted serially on strips 1, 2, 3, 4, 5, 6, and 7:

(a) Chemistry I (SF-546),

(b) Hematology (SF-549),

(c) Urinalysis (SF-550), and

(d) Serology (SF-551).

(2) The following Standard Forms be mounted on alternate strips 1, 3, 5, and 7:

(a) Chemistry II (SF-547);

(b) Chemistry II (Urine) (SF-548);

(c) Parasitology (SF-552);

(d) Spinal Fluid (SF-555); and

(e) Immunohematology (SF-556).

e. In many instances there will be a mixed assortment of Standard Forms to be mounted in a patient's chart and obviously these should be mounted in the most practical sequence.

f. Instructions for attaching the laboratory report forms to this display sheet are printed at the bottom of the SF-545. A check mark in the space in the lower right corner identifies the name of the laboratory forms that are displayed on this sheet or indicates that a variety or assortment of forms is displayed on the sheet.

19. SF-545a - Clinical Record - Laboratory Report Display for SF-553, SF-554, and SF-557. This is a display form for mounting Microbiology I, Microbiology II, and miscellaneous forms for inclusion in the health record. It may be used, when indicated, in addition to SF-514.

20. SF-546 - 557 (Laboratory Requests).

a. SF-546 (Chemistry I). Used to request most blood chemistry tests. Fill in the identification data as described previously. The specimen sources information is given by checking the box marked BLOOD or by specifying information in the position marked OTHER. The names of the blood chemistry tests are listed individually on this form. At the bottom of the list there is provision for ordering a battery or profile of tests. When requesting the identifying names of the battery or profile of tests must be written into the space provided. There is also space for writing in the names of other tests not specifically listed.

b. SF-547 (Chemistry II). Used to request blood gas measurement, T3, T4, serum, iron binding capacity, glucose tolerance, and other chemistry tests. Fill in the identification data as described previously. The specimen source information is given by checking the box marked BLOOD or by specifying information in the position marked OTHER.

c. SF-548 (Chemistry II, Urine). Used to request chemistry tests on urine specimens. The specimen interval information is given by checking the box marked 24 HOURS or by specifying information in the position marked OTHER.

d. SF-549 (Hematology). Used to request routine hematology tests. The specimen source information is given by checking box marked VEIN, the box marked CAP for capillary, or by specifying information in the position marked OTHER.

e. SF-550 (Urinalysis). Used to request urinalysis tests, including routine urinalysis with microscopic examination. The specimen source information is given by checking the box marked ROUTINE or by specifying information in the position marked OTHER. (Note that routine urinalysis may be ordered by simply placing an "X" in front of the word MICROSCOPIC in the requesting section.) The space marked PSP is for requesting and reporting phenolsulfonphthalein measurements. The space marked HCG is for requesting and reporting measurements of human chorionic gonadotropin.

f. SF-551 (Serology). Used to request tests that measure serum antibodies, including tests for syphilis.

(1) The space marked RPR is for requesting and reporting measurements of the Rapid Reagent Card Test for Syphilis

(2) The space marked TA is for requesting and reporting measurements of the Latex Fixation Test for Thyroglobulin Antibodies.

(3) The space marked COLD AGG is for requesting and reporting of Cold Agglutinins.

(4) The space marked ASO is for requesting and reporting Antistreptolysin 0 titers.

(5) The space marked CRP is for requesting and reporting measurements of C Reactive Protein.

(6) The space marked FTA-ABS is for requesting and reporting for fluorescent treponemal antibody-absorption test.

(7) The space marked FEBRILE AGG is for requesting and reporting measurements of Febrile Agglutinins.

(8) The space marked COMP FIX is for requesting and reporting Complement Fixation Tests. The name of the specific antibody should also be written in this space.

(9) The space marked HAI is for requesting and reporting Hemagglutination Inhibition Tests. The name of the specific antibody should also be written in this space.

g. SF-552 (Parasitology). Used to request tests for intestinal parasites, malaria and other blood parasites, as well as most test on feces. Fill in identification data as described previously.

h. SF-553 (Microbiology I). Used to request most bacteriological isolations and sensitivities.

(1) The type of the patient's infection, according to origin, is indicated by checking one of the boxes in the space marked INFECTION in the upper right area of the form.

(2) The examination requested is indicated by checking either the box marked SMEAR, SENSITIVITY, CULTURE, or COLONY COUNT.

(3) The report of the examination is written or stamped on the form by the laboratory personnel.

(4) The names of the bacteria identified or isolated are listed in the space marked PREDOMINANT ORGANISM(S).

(5) The sensitivity listing and results are stamped or written in the space marked SENSITIVITY.

i. SF-554 (Microbiology II). Used to request tests for fungi, acidfast bacillus (TB), and viruses.

(1) The type of infection according to origin is indicated by checking one of the boxes in the space marked INFECTION.

(2) The examination(s) requested is checked in the sections for fungus test or AFB tests or viral cultures.

(3) The test results are stamped or written on the form by the laboratory personnel.

j. SF-555 (Spinal Fluid). Used to request most spinal fluid tests.

k. SF-556 (Immunohematology). Used to request blood grouping, typing, and blood bank tests.

l. SF-557 (Miscellaneous). Used to request and report tests such as electrophoresis and assays of coagulation factors, which are not ordered on other laboratory forms.

(1) Fill in the identification data as described previously.

(2) The specimen source is specifically described in the space marked SPECIMEN SOURCE.

(3) Write the name of the test requested in the request section of the form.

21. **SF-519 (Radiographic Reports).** See Encl (1), pg.4-21.

a. This is a display form for mounting Radiographic Reports (SF-519-A). Attach the SF-519-A to the indicated spaces, with the most recent report on top.

b. Use SF-519-A to request x-ray examinations. All patient data must be completed as indicated. Ensure that examinations requested are in standard terms or abbreviations.

ALL pertinent clinical history, operations, physical findings, pregnancy status, and provisional diagnoses must be recorded in the appropriate space. This information is needed by the radiologist in order to render a proper interpretation of the film.

c. Complete the required patient's identification information.

22. **DD-771 (Eyewear Prescription)**. See Encl (1), pg.4-22. Type DD-771 for clarity and to avoid errors in interpretation, using the following format:

a. Date. Enter as follows, 22 JAN 87, etc.

b. Order Number. Enter unit identifying number, issued by NOSTRA or Top Gun Fantasy Ray Ban, above the order number block. Complete order number block if desired.

c. To. Appropriate fabricating facility.

d. From. Enter complete unit address of unit ordering the eyewear.

e. Name, Service Number/Social Security Number. Enter as ALBERT, Michael W. HSC 123-45-6789.

f. Age. Self-explanatory.

g. Unit and Address. Enter complete mailing address of unit to which individual is attached. If retiree, use the individual's home or mailing address.

h. Active Duty, etc. Check appropriate block.

i. USA, USN, etc. Check appropriate block.

j. Spectacles. Check appropriate block.

k. Aviation Spectacles. Use this block only when ordering aviation frames. Check as appropriate:

(1) N-15 tinted lenses;

(2) Coated lenses (coated with an anti-glare compound) are not authorized for Coast Guard personnel.

l. Other. Leave blank.

m. Interpupillary Distance. Copy directly from patient's Prescription, previous DD-771, or SF-600.

n. Eye Size. As above. (Not required for aviation goggles)

o. Bridge Size. As above. (Not required for aviation goggles)

p. Temple Length and Style. As above. (Not required for aviation goggles)

q. Number of Pairs. Enter the number of pairs requested.

r. Case. Enter the number of cases requested.

s. Single Vision.

(1) Sphere. Copy directly from individual's prescription, previous DD-771, or SF-600 (+1.00, -1.25, etc.). Prescriptions are filled in multiples of 0.25 diopters only.

(2) Cylinder. As above, except that prescriptions or multivision lenses must be in "minus cylinder" form, (-0.50, -0.75, etc.).

(3) Axis. Copy directly from individual's prescription, previous DD-771, or SF-600. The axis must contain three (3) digits such as: 180, 090, 005, etc.

(4) Decentration. Need not be completed unless specified as a part of prescription.

(5) Prism. As indicated on individual's prescription, previous DD-771, or SF-600.

(6) Base. As above.

t. Multivision. If the individual needs multivision lenses (bifocals, trifocals, etc.) then the prescription must be in minus cylinder form.

u. Special Lenses or Frames. This block is used for special instructions or justification for aviation spectacles, or nonstandard lenses, and frames, etc.

(1) When replacement eyewear is ordered from a prescription extracted from the health record, enter the following entry in this block: "REPLACEMENT ORDER: PRESCRIPTION FROM REFRACTION PERFORMED ON DATE."

(2) When eyewear is ordered for recruits, enter the following entry in this block: "RECRUIT - PLEASE EXPEDITE."

(3) When tinted lenses are ordered for non-aviation personnel, enter a written justification in this block. "Tinted lenses STATE JUSTIFICATION."

(4) When nonstandard temples or frames are ordered, enter type frame or temple requested, and justification:

(a) Riding Bow Cables, (Justification);

(b) Adjustable Nose Pads, (Justification).

(5) When an individual's pupillary distance is less than 60 mm it must be verified and an entry placed in this block: "PD of ____ verified and correct."

v. Signature of Approving Authority. Shall be signed by the senior medical officer, designated representative, or the commanding officer where no medical officer is present.

w. Signature of the Prescribing Officer. Shall be signed by the medical officer or person performing the refraction. When this is not possible, i.e., examination obtained from a civilian source, transcribed from the health record, etc., the person transcribing the information shall sign as prescribing officer. Flight surgeons may sign prescriptions as both the prescribing and approving authority.

23. **SF-601 (Immunization Record)**. See Encl (1), pg.4-23.

a. All prophylactic immunizations; sensitivity tests; reactions to transfusions, drugs, sera, food and allergies, and blood typings shall be recorded on SF-601 and also on the PHS-731. The recordings shall be continued on the current record until additional space is required under any single category.

b. In such cases, insert a new SF-601 in the health record and retain the old SF-601. Concurrently, make a thorough verification of the entries and bring all immunizations up-to-date. Replacement of the current SF-601 is not required because of change in grade, rating, or status of the member concerned.

c. The name of the individual administering the immunization or test, or determining the nature of the sensitivity reaction, shall be typed or a rubber stamp used. Signatures on SF-601 are not required. However, in the event of their use, make sure they are legible.

d. The individual administering the immunizations is responsible for completing all entries in the appropriate section, including required entries on reactions.

e. Enter information concerning a determined hypersensitivity to an immunization or vaccine under "Remarks and Recommendations". Type appropriate entries (such as HYPERSENSITIVE TO TYPHOID) in capitals. Enter "HIV antibody testing done (enter date(s))".

f. For Yellow Fever vaccine, record the origin and batch number.

24. **SF-602 (Syphilis Record).** See Encl (1), pg. 4-25.

a. This form shall be prepared and inserted in the health record for each person for whom a confirmed diagnosis of syphilis or any of its complications or sequela has been established.

b. The medical officer shall carefully and thoroughly explain to the patient the nature of the infection and the reasons why treatment, prolonged observation and the repeated

performance of certain prescribed tests are necessary. The patient shall then be requested to sign the statement in Section II of SF-602.

24. **DD-1141 (Record of Occupational Exposure to Ionizing Radiation)**. See Encl (1), pg.4-27.

a. Requirements. The custodian of the medical records shall prepare and maintain as DD-1141 for each person occupationally exposed to ionizing radiation. Enter all exposures in rems.

b. Recording Procedures.

(1) Initial Determination of Accumulated Dose.

(a) In the initial preparation of DD-1141, obtain complete reports of previous exposure. For each period in which the individual was engaged in activities where occupational exposure was probable, and no record, or only an incomplete record of exposure during the period can be obtained, assume that an occupational exposure of 1.25 rems was incurred per quarter of each calendar year or fraction thereof.

(b) In cases where the nature of the radiation is unknown, assume gamma radiation.

(c) If an individual was exposed at more than one facility, calculate the cumulative exposures and record them in Items 7 through 12 as appropriate. Enter the sum of the whole body exposure in Item 13, and a statement regarding the sources of that information in Item 16, REMARKS.

(2) Current Record.

(a) Quarterly, make appropriate entries on each individual's DD-1141 from the exposure records received from the Public Health Service Contractor.

(b) Maintain separate DD-1141 to record exposures other than whole body, with appropriate descriptions under Item 16, REMARKS.

c. Completion Instructions.

(1) Item 1. Leave blank.

(2) Item: 2. Enter last name, first name, and middle initial. If the combination of last name and first name exceed 19 spaces, enter last name and initials only.

(3) Item 3. Enter SSN.

(4) Item: 4. Enter in not more than 10 spaces, rate, grade, title or position the individual is currently holding. Use standard service abbreviations: i.e.,

CAPT; HSCS; HSl; etc. Abbreviate civilian occupation titles as needed; i.e., Radiological Physicist to Rad Physic; Radiation Physiologist to Rd Physiol; Electrical Welder to Elec Wldr; etc.

(5) Item 5. Enter date of birth: i.e., 4 SEP 87.

(6) Item 6. Enter name of activity or unit.

(7) Items 7 & 8. "Period of Exposure." Enter the day, month, and year: i.e., 1 MAR 87.

(8) Items 9-12. "Dose This Period." Enter radiation dose received this period to three decimal places: i.e., 02.345rem. Use five digits including zeros as necessary for all entries.

(a) Item 9. Enter skin dose (soft) which includes low energy gamma and x-ray of less than 20 KVE effective energy and beta radiation. Total skin dose is the addition of columns 9 and 12.

(b) Item 10. Enter gamma and x-ray dose greater than 20 KVE effective energy in REM.

(c) Item 11. Enter neutron dose in REM.

(d) Item 12. Enter sum of items 10 and 11.

(9) Item 13. Add item 12 to previous item 13; enter total in item 13.

(10) Item 14. Enter permissible dose calculated from the age formula 5(N-18) REM, where N equals the present age in years.

(11) Item 15. Recorder certify entries by initial.

(12) Item 16. Enter other pertinent information such as known exposure from internally deposited radioactive material or from any external radioactive sources. Describe briefly any activity or assignment bearing a potential for exposure and estimate dose-time relationships, if feasible. If this form is used for other than whole body and skin of whole body, specify the use; i.e., hands and forearms, feet and ankles, thyroid, etc. When recorded dose is not obtained from film badge readings, specify whether estimates were obtained from pocket dosimeters, area or air monitoring, bioassay, etc.

25. **CG-4057 (Chronological Record of Service).** See Encl (1), pg 4-28.

a. Purpose. Use this form:

(1) to maintain a chronological record of assignments for each active duty member of the Coast Guard;

(2) as a statement of agreement or disagreement with the assumption of fitness for duty upon separation from the Coast Guard; and

(3) to terminate the health record.

b. Chronological record of assignments. Prepare original only. Record the member's full name in all capitals, together with the Social Security Number. Make entries each time a member leaves or returns from PCS, TAD, or hospitalization at a unit different than the one to which currently assigned.

c. Agreement or disagreement with the assumption of fit for duty at the time of separation. Members not already in the physical disability evaluation system, who disagree with the assumption of fitness for duty at separation shall indicate on the reverse of form CG-4057. They shall then proceed as indicated in paragraph 3-B-5. of this Manual. Members who agree with the assumption shall check the box indicating agreement. This is a health services department responsibility when there is a health services department representative attached; otherwise it becomes a personnel action.

d. Terminating the health record. The reverse side of the form is also used to terminate a member's health record upon definite separation from active service. The date of termination is the effective date of separation. Make appropriate entries giving the reason for termination, the date of termination and the grade and signature of the responsible commissioned officer in the bottom portion of the form. Additionally, an entry, signed by the member whose health record is being terminated, acknowledging the receipt of a copy all available NAVMED 6150/20's, a copy of separation examination if done (either DD-2808 or SF-600 entry), a signed copy of the CG-4057, and the PHS-731 shall be made in the Remarks section of the CG-4057.

e. This form is also used to notify the individual of the possibility of certain disability benefit entitlements from the Department of Veterans Affairs after separation.

f. If either side of the CG-4057 is filled, the reverse side shall have a line drawn diagonally through it in red and a second CG-4057, marked "Supplement" at the top, started.

26. **NAVMED 6150/2 (Special Duty Medical Abstract)**. See Encl (1), pg. 4-30.

a. General. The purpose of the NAVMED 6150/2 is to provide a record of physical qualifications, special training, and periodic examinations of members designated for performing special duty, such as aviation and diving. The object of the special duty examination, and the instructions incident thereto, is to select only those individuals who are physically and mentally qualified for such special duty, and to remove from such status those members who may become temporarily or permanently unfit for such duty because of physical or mental defects. Also, in this connection, special money disbursements are often based upon the determination of a member's physical and mental qualifications or continued requalification for performing a special duty.

Therefore, accuracy and content of information are essential in reporting information applicable to these categories.

b. Entries.

(1) Record entries upon completion of each physical examination and completion of designated special training. When a previously qualified member is suspended from special duty for physical reasons, enter the period of suspension and reason therefore on the NAVMED 6150/2.

(2) The scope of the physical examination and technical training prescribed for these special categories often differs from the general service requirements; therefore, entries reporting results which pertain to these particular examinations or training involved shall be approved only by medical officers.

27. PHS-731 (International Certificate of Vaccination).

a. General.

(1) Prepare PHS-731 for each member of the Coast Guard (for reserve personnel when ordered to Active Duty for Training). This form shall be carried only when performing international travel or when reporting for Active Duty for Training. When not required for either of the preceding reasons, the completed certificate shall be retained in the individual's health record. Appropriate entries shall be made on PHS-731 and SF-601 when immunizations are administered.

(2) A reservist not on extended active duty who plans international travel either under official orders or privately, may request that the appropriate district commander (r) furnish a PHS-731 for this purpose. The reservist shall return the PHS-731 to the district commander (r) when travel is completed.

(3) When properly completed and authenticated, the PHS-731 contains a valid certificate of immunization for international travel and quarantine purposes in accordance with World Health Organization Sanitary Regulations.

(4) All military and nonmilitary personnel performing international travel under Coast Guard cognizance shall be immunized in accordance with Commandant Instruction 6230.4 (series) and shall have in their possession a properly completed and authenticated PHS-731.

b. Detailed Instructions.

(1) Stamp or type the following address on the front of PHS-731:

Commandant (G-WK)

U. S. Coast Guard

2100 Second St., S.W.

Washington, DC 20593-0001

(2) Enter data by hand, rubber stamp, or typewriter.

(3) Enter the day, month, and year in the order named (i.e., 4 SEP 87).

(4) Record the origin and batch number for yellow fever vaccine.

(5) Entries for cholera and yellow fever must be authenticated by the Department of Defense Immunization Stamp and the actual signature of the medical officer. Other immunizations may be authenticated by initialing. Entries based on prior official records shall have the following statement added: "Transcribed From Official Records."

c. Remove the PHS-731 from the health record and give it to the individual upon separation from the Service.

28. **CG-5214 (Emergency Medical Treatment Report).** See Encl (1), pg. 4-32.

a. Purpose. CG-5214 provides a multiple copy record of all emergency medical care rendered by Coast Guard personnel outside of a clinic or sickbay. All care rendered by crews of Coast Guard emergency vehicles must be documented with a CG-5214.

(1) Part 1, Copy to Patient. This copy shall be placed in the patients' health record if available.

(2) Part 2, Copy to Receiving Unit. This copy shall be given to the hospital, clinic, or EMS crew assuming responsibility for patient care.

(3) Part 3, Copy to Triage Officer. In multi-casualty incidents, this copy shall be given to the triage officer to account for the patients' treatment priority and status. Otherwise, this copy shall be kept on file at the clinic or sickbay.

(4) Part 4, (hard copy) to Commandant (G-WKH-1). This copy shall be forwarded to Commandant (G-WKH-1) using the mailing label on the reverse side.

b. Preparation and Submission of CG-5214. The form provides an accurate account of the patient's injury or illness, and a detailed report of all treatments rendered en route to a receiving facility. If possible, the report should be completed during the transport phase. Detailed instructions for completing the CG-5214 are as follows:

(1) Victim Identification.

(a) Item 1: Name. Enter last, first, and middle initial.

(b) Item 2: Sex. Check one.

(c) Item 3: Estimated Age. Enter in years or months.

(2) Description of Incident.

(a) Item 4: Date. Enter date incident occurred.

(b) Item 5: Type of Incident. Check one and give pertinent details under "Nature of Emergency/Mechanism of Injury".

(c) Item 6: Time on Scene. Enter (using 24 hour clock).

(d) Item 7: Time of Incident. Enter (using 24 hour clock).

(e) Item 8: Location. Enter exact geographical area.

(3) Observation of Victim. Stick-Man figure: Place applicable injury letter code over injured area.

(4) Skin. Circle applicable number.

(5) Vital Signs. Note time observed (24 hour clock).

(6) Level of Consciousness. Check only one per time observed.

(7) Pupils. Check only one per time observed.

(8) Pulse. Place numerical value under rate and check appropriate space for quality.

(9) Breathing. Place numerical value under rate and check appropriate space for quality.

(10) Blood Pressure. Enter systolic and diastolic values under applicable time.

(11) Temperature. Circle either oral or rectal and enter in numerical value.

(12) Mast. Beside "Mast BP" enter blood pressure values. Circle applicable compartments inflated.

(13) Triage Information. Circle one of the following:

(a) Priority I: Patients with airway and/or breathing problems, cardiac arrest, uncontrolled bleeding or controlled bleeding with symptoms of shock, severe head or abdominal injuries, and severe medical problems to include possible heart attack, severe burns, and severe poisonings.

(b) Priority II: Patients with less serious burns, multiple fractures, potential C-Spine injuries without shock, or medical conditions of a less serious note.

(c) Priority III: Patients with obvious minor injuries or patients who are obviously dead or mortally wounded.

(14) Medications. List any medications the patient is currently taking.

(15) Allergies. List any known allergies for the patient.

(16) Medications Administered. Note the time, dosage, and route of administration for any medications administered to the patient.

(17) Rescuer Information.

(a) Item 10: Name. Enter last, first, and middle initial.

(b) Item 11: Level. Circle appropriate certification level.

(c) Item 12: Unit. Rescuer's assigned unit.

(d) Item 13: OPFAC#. Enter.

(e) Item 14: rescue Vehicle. Identity of the responding vehicle, vessel, or aircraft.

(f) Item 15: Receiving Unit. Hospital, EMS vehicle, or clinic assuming responsibility for patient care.

(g) Time Patient Transferred. Enter (24 hour clock).

29. **DD877 (Request for Medical/Dental Records or Information)**. See Encl (1), pg. 4-33.

a. Purpose. The DD 877 is a self-carboning triplicate form which is used to forward health and clinical records between clinics and units as well as to request records from clinics, units, or MTFs.

b. General. This form shall be initiated and included with health and clinical records as directed in Chapter 4-A-6. And 4-D-7. Of this Manual

c. Detailed Instruction.

(1) Each DD877 must have all boxes completed.

(2) n all instances when a DD877 is initiated, remarks concerning the reason for sending the record, the name of the gaining unit for the member/ sponsor and a request for action will be included on the form. When preparing a DD877 for a record to be forwarded, place the following in section 9., REMARKS: “Health {clinical} record for this member (family member) is forwarded to you for appropriate filing. Member (sponsor) assigned to (insert gaining unit name).”

(3) For members entering the inactive reserve, enter the following in section 9, remarks**: " member entering inactive reserve in your district**. Per Medical Manual, COMDTINST M6000.1B, Chapter 4-B-4.b.,this health record is forwarded for appropriate action."

(4) A copy of the DD877 will be retained at the unit sending the record for 6 months after the record is mailed, then may be discarded.

Section C - Dental Record Forms.

1. **CG-3443-2 (Dental Record Cover).** See Encl (1), pg. 4-34.

   a. Open a CG-3443-2 for each individual upon arrival at a training center or initial entry into the Coast Guard or Coast Guard Reserve. When an individual on the retired list returns to active duty, submit a request for a copy of the closed out dental record to Commandant (G-PIM). Whenever the original record is lost or destroyed, a new dental record shall be opened immediately. Normally the dental record shall be kept in the Health Record Cover (CG-3443) of each individual unless otherwise specified.

   b. All dental forms and radiographs will be contained in the Dental Record.

   c. Detailed Instructions.

      (1) Surname. Record the surname in all capital letters.

      DOE

      SURNAME

      (2) Given name(s). Record in full without abbreviation. If the individual has no middle name or initial then record the lower case letter "n" in parentheses (n). If the individual has only a middle initial(s), record each initial in quotation marks. When "Jr." or "II" or other similar designations are used, they shall appear after the middle name or initial.

      DOE JANE ANN

      SURNAME First Name Middle Name

      (3) Social Security Number (SSN). Enter Social Security Number.

      (4) Date of Birth. Enter day, month (abbreviated JAN, FEB, MAR, etc.), and the year: i.e., 4 SEP 49.

      (5) Change in Grade or Rate. Enter as they occur.

      (6) Blood Type. Enter the individual's blood type in the appropriate box. If not known, perform a blood type test.

      (7) RH Factor. Enter the individual's RH factor in the appropriate box. If not known, perform an RH factor test.

      (8) Drug Sensitivity Sticker. When required, affix the Drug Sensitivity Sticker (CG-5266) to the lower left corner of the front of the Dental Record Cover. Do not cover other identification data. **See Encl (1) pg. 4-34.**

      (9) Dental Radiographs.

(a) Dental Bitewing Radiograph Storage. Bitewing radiographs shall be stored in the standard stock 5 year x-ray card (FSC# 6525-00-142-8732). This shall replace the single bitewing x-ray card (FSC# 6525-00-817-2364). X-ray film is mounted in the x-ray card with the raised dot side of the film on the back side of the card.

2. **NAVMED 6600/3 (Dental Health Questionnaire)**. See Encl (1), pg. 4-35.

a. General. CG-5605 will help the dental officer detect any present or past health problem (i.e., positive Human Immunodeficiency Virus (HIV)) that might interfere with definitive dental treatment. All positive answers from the health history section must be followed up by the dental officer for impact on health care and so annotated on the CG-5605 and/or the SF-603A.

b. Detailed Instructions. Insert the Dental Health Questionnaire as the first page of the dental record. Patients shall fill out a new Dental Health Questionnaire at least annually, or when information changes. Maintain the two most recent forms in the dental record with the current CG-5605 on top.

(1) Chief Complaint. Have the patient enter the problem they are presently having.

(2) Check and Sign. Have the patient enter yes/no in each box of the history. The signature indicates the authenticity of the history.

(3) Summary of Pertinent Findings. Include baseline BP reading.

3. **SF-603 (Dental Record).** See Encl (1), pg. 4-36.

a. General. The Dental Record is a continuous history and must contain accurate and complete entries of dental examinations and treatments. Each entry shall clearly indicate the name of the dental officer conducting the examination and/or rendering the treatment. Dental hygienists or other auxiliary personnel providing care shall also follow this requirement. Each dental officer is personally responsible for ensuring that all entries are properly recorded.

b. Numerical Classification for Record Purposes. Chart markings have been standardized so that dental conditions, treatments needed, and treatments completed may be readily identified. This facilitates efficient continuity of treatments and may establish identification in certain circumstances.

(1) For the purpose of brevity and exactness, use the following classification of teeth in keeping the dental record.

TOOTH	DESIGNATION
Right Maxillary Third Molar	1
Right Maxillary Second Molar	2

Right Maxillary First Molar	3
Right Maxillary Second Bicuspid	4
Right Maxillary First Bicuspid	5
Right Maxillary Cuspid	6
Right Maxillary Lateral Incisor	7
Right Maxillary Central Incisor	8
Left Maxillary Central Incisor	9
Left Maxillary Lateral Incisor	10
Left Maxillary Cuspid	11
Left Maxillary First Bicuspid	12
Left Maxillary Second Bicuspid	13
Left Maxillary First Molar	14
Left Maxillary Second Molar	15
Left Maxillary Third Molar	16
Left Mandibular Third Molar	17
Left Mandibular Second Molar. .	18
Left Mandibular First Molar	19
Left Mandibular Second Bicuspid	20
Left Mandibular First Bicuspid	21
Left Mandibular Cuspid	22
Left Mandibular Lateral Incisor	23
Left Mandibular Central Incisor	24
Right Mandibular Central Incisor	25
Right Mandibular Lateral Incisor	26
Right Mandibular Cuspid	27
Right Mandibular First Bicuspid	28
Right Mandibular Second Bicuspid	29
Right Mandibular First Molar	30
Right Mandibular Second Molar	31
Right Mandibular Third Molar	32

(2) Indicate deciduous teeth by placing a block "D" around tooth number. If both permanent and deciduous teeth are present, place a "D" in location of deciduous tooth and enter the appropriate tooth number inside the "D."

(3) Indicate a supernumerary tooth by placing "s" in the location of the supernumerary tooth and in the remarks section enter a statement that the examinee has a supernumerary tooth.

(4) Indicate deciduous and supernumerary teeth on the SF-603 in SECTION I, Part 5 (Diseases, Abnormalities, and Radiographs) and enter a statement in the remarks section of Section 5.

c. Detailed Instructions.

SECTION I. DENTAL EXAMINATION

(1) Purpose of Examination. To assess the oral health status of cadets, officer candidates and enlisted recruits upon initial entry into the Coast Guard, and to provide periodic (but at least annual) examinations of active duty personnel. Enter an "X" in the appropriate box. Mark the "Initial" box for the dental examination made upon entrance into the Coast Guard. All other examinations fall under the "Other" category and shall be identified: i.e., "Academy", "Reenlistment", etc.

(2) Type of Examination. Enter an "X" in the proper box of item 2, "Type of Exam."

(a) Type 1, Comprehensive Examination. Comprehensive hard and soft tissue examination, which shall include: oral cancer screening examination; mouth-mirror, explorer, and periodontal probe examination; adequate natural or artificial illumination; panographic or full-mouth periapical, and posterior bitewing radiographs as required; blood pressure recording; and when indicated, percussive, thermal, and electrical tests, transillumination, and study models. Included are lengthy clinical evaluations required to establish a complex total treatment plan. For example, treatment planning for full mouth reconstruction, determining differential diagnosis of a patient's chief complaint, or lengthy history taking relative to determining a diagnosis. Use S.O.A.P. format to record the results of a Type 1 examination.

(b) Type 2, Oral Examination (annual or periodic). Hard and soft tissue examination, which shall include: oral cancer screening examination; mouth mirror and explorer examination with adequate natural or artificial illumination; periodontal screening; appropriate panographic or intraoral radiographs as indicated by the clinical examination; and blood pressure recording. An appropriate treatment plan shall be recorded. This type is the routine examination which is normally performed one time per treatment regimen per patient, unless circumstances warrant another complete examination. Use S.O.A.P. format to record the results of Type 2 examination.

(c) Type 3, Other Examination. Diagnostic procedure as appropriate for: consultations between staff; observation where no formal consult is prepared; certain categories of physical examination; and emergency oral examination for evaluation of pain, infection, trauma, or defective restorations.

(d) Type 4, Screening Evaluation. Mouth mirror and explorer or tongue depressor examination with available illumination. This includes the initial dental processing of candidates without necessarily being examined by a dentist, or other dental screening procedures.

(e) If not specified by this Manual, it shall be the professional responsibility of the dental officer to determine the type of examination which is appropriate for each patient. However, Type 3 and Type 4 examinations are not adequate to definitively evaluate the oral health status of patients. When the dental officer determines that a comprehensive periodontal examination is to be accomplished, use the Navy Periodontal Chart, NAVMED 6660/2 (3-90).

(3) Dental Classification of Individuals. Dental classifications are used to designate the health status and the urgency or priority of treatment needs for active duty personnel. Use the following guidelines and criteria for the classification of patients. When a criterion for a specific condition is not listed, the dental officer shall evaluate the prognosis for a dental emergency and assign the appropriate classification.

(a) Class 1. Patients who do not require dental treatment. The following are criteria for such classification.

7 no dental caries or defective restorations;

8 healthy periodontium, no tooth accumulated materials (hard or visible soft deposits);

9 stable occlusion, asymptomatic temporomandibular joint;

10 unerupted or malposed teeth that are without historical, clinical, or radiographic signs or symptoms of pathosis, and are not recommended for prophylactic removal; and

11 no edentulous spaces for which a prosthesis is indicated.

(b) Class 2. Patients who have dental conditions that are unlikely to result in a dental emergency within 12 months. Class 2 dental patients are considered fit for operational duties, but the dental diseases or conditions causing designation shall be reevaluated at each dental examination. Any one of the following is a sufficient criterion for such a classification:

1 Dental caries, decalcification, or tooth fractures extending beyond the dentinoenamel junction, or causing definitive symptoms;

2 Restorations with fractures or marginal defects;

3 Periodontal diseases or periodontium exhibiting;

a nonspecific gingivitis. Inflammation of the gingiva characterized by changes in color, gingival form, position, surface appearance, bleeding upon brushing or flossing, or the presence of blood or exudate after probing with a periodontal probe;

b slight or mild adult periodontitis. Progression of the gingival inflammation into the deeper periodontal structures and alveolar bone crest with accompanying periodontal probing depths of from 3 to 4mm, slight loss of connective attachment, and slight loss of alveolar bone;

c moderate periodontitis. Gingival inflammation with destruction of the periodontal structures including radiographic or clinical evidence of loss of alveolar bone support, with possible early furcation involvement of multirooted teeth or tooth mobility;

d stable or nonprogressive mucogingival conditions. This includes conditions such as irregular marginal contours, gingival clefts, and aberrant frena or muscle attachments, which could potentially progress, or pathosis but are currently stable and compatible with periodontal health; or

e past history of periodontal disease or therapy when the disease is currently under control in a long-term maintenance program.

4 The presence of supragingival or subgingival tooth accumulated materials without concomitant periodontal disease.

5 Prosthodontics indicated. Edentulous areas, provisional/interim/temporary prostheses, defective prostheses, provisional crowns, large extracoronal direct restorations, or endodontically treated teeth without full coverage, that need prosthetic treatment but delay will not compromise the patients immediate health or masticating function.

6 Unerupted, nonfunctional, or malposed teeth without historical, clinical, or radiographic signs or symptoms of pathosis, but which are recommended for prophylactic removal to prevent future pathologic conditions (e.g., unopposed or unerupted third molars, or malposed teeth which complicate plaque control measures).

7 Preventive dentistry requirements not fulfilled.

8 Those conditions described in subparagraphs 4. through 7. above are not considered disqualifying for overseas, sea duty, or isolated duty assignment.

(c) Class 3. Patients who have dental conditions that are likely to cause a dental emergency within 12 months. The following conditions have the potential to cause an emergency, and any one is sufficient criterion for disqualification for overseas or isolated duty assignment:

1 Periodontal diseases or periodontium exhibiting:

2 Advanced periodontitis. Significant progression of periodontitis with major loss of alveolar bone support and probable complex furcation involvement of multirooted teeth and increased tooth mobility. The periodontal probing depth may reach 7mm and deeper;

a. periodontal abscess;

b. acute necrotizing ulcerative gingivitis (NUG);

c. periodontal manifestations of systemic diseases and hormonal distubances (e.g., acute herpetic gingivostomatitis);

d. refractory, rapidly progressive periodontitis. Rapid bone and attachment loss, or slow but continuous bone and attachment loss resistant to normal therapy; or

e. juvenile and prepubertal periodontitis, either localized or generalized.

3 Acute or chronic pulpitis.

4 Indication of periradicular pathosis with or without existing root canal filling which may require treatment.

5 Presence of a tooth or teeth undergoing endodontic therapy.

6 Stomatitis.

7 Pericoronitis.

8 Prosthodontics required to replace an existing prosthesis exhibiting dental caries, or a large defective amalgam restoration requiring replacement with a casting. Also, appliances required due to:

9 Insufficient masticatory function, active arch collapse from tooth loss, or essential performance of military duties (e.g., replacement of missing teeth for esthetics or phonetics);

10 soft tissue inflammation, such as papillary hyperplasia under a denture base;

11 an essential prosthesis in need of repair in order to be functional; or

12 a provisional, interim, or temporary prosthesis which cannot be maintained for a 12 month period.

13 Unerupted, partially erupted, nonfunctional or malposed teeth associated with historical, clinical or radiographic evidence of pathosis, or with a high potential to cause a dental emergency.

14 Soft or hard tissue lesions requiring an incisional or excisional biopsy for the definitive diagnosis and treatment of the lesions, including the period of time awaiting the results of the histopathologic examination.

15 Appropriate postoperative treatment not yet completed, including suture removals for surgery and occlusal adjustments for restorative dentistry.

16 All conditions requiring immediate treatment for relief of pain, traumatic injuries, or acute oral infections.

17 Orthodontic therapy in progress, with either fixed or removable appliances.

(4) Priority of Dental Treatment. To further indicate priority of treatment within a class, the following groupings shall be used when necessary (listed in order of decreasing priority).

(a) Group 1. Coast Guard active duty personnel in receipt of orders to sea, overseas, or combat duty.

(b) Group 2. Coast Guard active duty personnel upon return from sea, overseas, or combat duty.

(c) Group 3. Other Coast Guard personnel.

(d) Group 4. Active duty personnel of other Services assigned to duty with the Coast Guard.

(e) Group 5. Active duty personnel of other Services.

(f) Missing Teeth and Existing Restorations.

(g) Markings shall be made on examination chart as follows:

1 Missing Teeth. Draw a large "X" on the root(s) of each tooth that is not visible in the mouth.

2 Edentulous Mouth. Inscribe crossing lines, one extending from the maxillary right third molar to the mandibular left third molar and the other from the maxillary left third molar to the mandibular right third molar.

3 Edentulous Arch. Make crossing lines, each running from the uppermost aspect of one third molar to the lowest aspect of the third molar on the opposite side.

4 Amalgam Restorations. In the diagram of the tooth, draw an outline of the restoration showing size, location, and shape, and block solidly.

5 Nonmetallic Permanent Restorations (includes oxyphosphate cements). In the diagram of the tooth, draw an outline of the restoration showing size, location, and shape.

6 Gold Restorations. Outline and inscribe horizontal lines within the outline.

7 Combination Restorations. Outline showing overall size, location, and shape; partition and junction materials used and indicate each, as in "4." above.

8 Porcelain Facings and Pontics. Outline.

9 Acrylic Resin Facings and Pontics. Outline each aspect.

10 Porcelain Post Crowns. Outline the crown and approximate size and position of the post(s).

11 Acrylic Resin Post Crowns. Outline crown and approximate size and position of the post(s).

12 Porcelain Jacket Crowns. Outline each aspect.

13 Acrylic Resin Jacket Crowns. Outline each aspect.

14 Fixed Bridges. Outline each, showing overall size, location, teeth involved and shape by the inscription of diagonal lines in abutments and pontics.

15 Removable Appliances. Place an "X" through the missing tooth, place a line over replaced teeth and describe briefly in "Remarks."

16 Root Canal Fillings. Outline canal filled and black in solidly.

17 Apicoectomy. Draw a small triangle apex of the root of the tooth involved, the base line to show the approximate level of root amputation.

18 Drifted Teeth. Draw an arrow from the designating number of the tooth that has moved; the point of the arrow to indicate the approximate position to which it has drifted. Under "Remarks" note the relationship to the drifted tooth in respect to occlusion.

(h) If an individual is appointed or enlisted with dental defects which have been waived, the defects shall be described fully in the dental record under "Remarks" (Section I).

(i) The examining dental officer shall sign, date, and record the place of examination where indicated.

(5) Diseases, Abnormalities, and Radiographs.

(a) Markings on the examination chart of Diseases, Abnormalities, and Radiographs shall be made as follows:

1 Caries. In the diagram of the tooth affected, draw an outline of the carious portion, showing size, location and shape, and block in solidly.

2 Defective Restoration. Outline and block in solidly the restoration involved.

3 Impacted Teeth. Outline all aspects of each impacted tooth with a single oval. Indicate the axis of the tooth by an arrow pointing in the direction of the crown.

4 Abcess. Outline approximate size, form, and location.

5 Cyst. Outline the approximate form and size in relative position of the dental chart.

6 Periodontal Disease. Inscribe a horizontal continuous line on the external aspect of root(s) involved in a position approximating the extent of gingival recession or the clinical depth of the pocket. If known, indicate the position of the alveolar crest by a second continuous line in relative position to the line indicating the gingival tissue level.

7 Extraction Needed. Draw two parallel vertical lines through all aspects of the tooth involved.

8 Fractured Tooth Root. Indicate fracture with a zigzag line on outline of tooth root.

(b) A statement regarding hypersensitivity to procaine or any other drug known to the person for whom a Dental Record is prepared shall be entered under "Remarks." (Example: HYPERSENSITIVITY TO PROCAINE)

(c) Complete items A through E.

(d) The examining dental officer shall sign, date, and record the place of examination where indicated.

(e) NOTE: Section I, Subsections 4 and 5 of SF 603 are used to record findings of initial and replacement examinations. These charts shall not be altered thereafter.

SECTION II. PATIENT DATA

(1) Patient Data. Complete items 6 through 14 as indicated.

SECTION III. ATTENDANCE RECORD

(1) Restorations and Treatments (Completed during service) (Item 15).

(a) Record restorations or treatments provided a patient after the initiation of a Dental Record on the chart "Restorations and Treatments" of Section III, in accordance with the following:

1 Carious Teeth Restored. In the diagram of the tooth involved, draw an outline of the restoration showing size, location and shape, and indicate the material used. Amalgam restorations would be outlined and blocked in, silicate cement restorations outlined only, etc.

2 Extractions. Draw a large "X" on the root(s) of each tooth extracted.

3 Root Canal Fillings. Outline each canal filled on the diagram of the root(s) of the tooth involved and block it in solidly.

4 Apicoectomy. Draw a small triangle on the root of the tooth involved, apex away from the crown, the base line to show the approximate level of tooth amputation.

5 Bridge and Crowns. Outline and fill in as specified above.

6 Removable Appliances. Place a line over numbers of replaced teeth and give a brief description under "Remarks."

7 Unrecorded Operations and Conditions. Operations performed by other than Coast Guard dental officers subsequent to the original

examination will be indicated by the dental officer discovering the condition just as if they had been done by a Coast Guard dental officer. Make appropriate entries indicating the nature of the treatment and adding the abbreviation "CIV" or other abbreviation as the case may be. The date entered will be the date of the discovery.

8 Other. Similarly, note operations known to have been performed by Coast Guard dental officers whose identity is not recorded, except use the abbreviation "CGDO." The date entered shall be the date the operation is discovered. Account for teeth which are shown as missing in the chart, Missing Teeth and Existing Restorations, and which have erupted subsequently, by an entry in the following manner: "1 and 32," eruption noted, date, and signature of dental officer making the notation. Record other conditions of comparable importance in a similar manner.

(b) Record a series of treatments for a specific condition not producing lasting changes in dental characteristics by entering of initial and final treatment dates (i.e., POT daily 1 AUG 87 thru 5 AUG 87 or Vin Tr. twice daily 1 AUG 87 thru 10 AUG 87).

(c) Authenticate each entry in this record by a written entry in the spaces provided under "Services Rendered."

(2) Subsequent Disease and Abnormalities (Item 16). Chart subsequent conditions, in pencil only, using the instructions in Chapter 4-C.3.(6). Once treatment is completed and documented in item 17, erase pencil entry in item 16 and permanently transfer in ink to item 15 (Restorations and Treatments).

(3) Services Rendered (Item 17). The accuracy and thoroughness in recording patient histories and treatment progress notes are essential elements in the diagnosis and treatment of the dental patient. In addition to the conventional listing of the tooth number and procedure, every effort shall be made to specifically identify dental materials used intraorally. Use trade names where possible. This includes, but is not limited to; bases and liners, metallic and nonmetallic restorative materials, denture frameworks and bases, impression materials, medicaments, and anesthesia. Record prescribed medications.

(a) Standard S.O.A.P. format. The S.O.A.P. format shall be used to document all sickcall and emergency dental treatments, to document Type 1 and Type 2 examinations, and to record the results of the examination of patients in preparation for comprehensive treatment planning. S.O.A.P. format is not required to document ongoing delivery of treatment which has been previously planned. All entries are to be on the SF-603/603-A, item 17. The S.O.A.P. format uses a problem oriented record as a tool in management of patient care. The acronym is derived from the first letter of the first four record statements as follows:

1 **"S" Subjective data**. This data includes the reason for the visit to the dental clinic, and if appropriate, a statement of the problem (chief complaint) and the qualitative and quantitative description of the symptoms appropriate to the problem.

2 **"O" Objective data**. A record of the type of examination and the diagnostic aids, including the ordering of radiographs, and the actual clinical findings, x-ray results, or laboratory findings appropriate to the problem. This is to include all the provider's findings such as carious teeth, inflammation, periodontal status, pocket depths, blood pressure measurement, etc.

3 **"A" Assessment**. This portion is the assessment of the subjective data, objective data, and the problem statement which leads the provider to a diagnosis, e.g.,"needs" (existing conditions or pathoses).

4 **"P" Plan**. This is the plan of treatment to correct or alleviate the stated problems or needs, irrespective of the treatment capability of the dental treatment facility. Include recommended treatment and, as appropriate, possible complications, alternative treatment, and prognosis with and without intervention. Include consultations, a record of the specific treatment performed, pre- and postoperative instructions, prescriptions, and any deviations from the original treatment plan.

(b) The following classification of tooth surfaces are listed in order of precedence and shall be used in connection with recording restorations of defective teeth:

Surface	**Designation**
Facial (Labial) (Anterior teeth)	F
Buccal (Posterior teeth)	B
Lingual	L
Occlusal (Posterior teeth)	0
Mesial	M
Distal	D
Incisal (Anterior teeth)	I

(c) Use combinations of designators to identify and locate caries, operations, or restorations in the teeth involved; for example, 8-MID would refer to the mesial, incisal, and distal aspects of the left mandibular cuspid; 30-MODF, the mesial, occlusal, distal, and facial aspects of a right mandibular first molar.

Surface	Designation
Mesial-Occlusal	MO
Distal-Occlusal	DO
Mesial-Incisal	MI
Distal-Incisal	DI
Occlusal-Facial	OF
Occlusal-Lingual	OL
Incisal-Facial	IF
Incisal-Lingual	IL
Mesial-Occlusal-Distal	MOD
Mesial-Occlusal-Facial	MOF
Mesial-Occlusal-Lingual	MOL
Mesial-Incisal-Distal	MID
Mesial-Incisal-Facial	MIF
Mesial-Incisal-Lingual	MIL
Distal-Occlusal-Facial	DOF
Distal-Occlusal-Lingual	DOL
Mesial-Occlusal-Distal-Facial	MODF
Mesial-Incisal-Distal-Facial	MIDF
Mesial-Occlusal-Distal-Facial-Lingual	MODFL
Mesial-Incisal-Distal-Facial-Lingual	MIDFL

(d) The use of abbreviations is not mandatory but is desirable for purposes of brevity in view of the limited space available in the dental record for recording services rendered. Whenever there is a possibility of misinterpretation due to the use of abbreviations, dental operations shall be written in full. When abbreviations are used, they shall conform to the following:

Operation, Condition, or Treatment	Abbreviation
Abrasion	Abr.
Abscess	Abs.
Acrylic	Acr.
Adjust (ed)(ment)	Adj.
Alveolectomy	Alvy.
Amalgam	Am.

Anesthesia	Anes.
Apicectomy	Apcy.
Base	B.
Bridge (denotes fixed unless otherwise noted)	Br.
Caries	Car.
Calculus	Cal.
Cavity Varnish	C.Var.
Cement	Cem.
Composite Resins	Comp. Res.
Crown	Cr.
Deciduous	Dec.
Defective	Def.
Denture (full unless otherwise noted)	Dtr.
Drain.	Drn.
Dressing	Drs.
Equilibrate (action)	Equil.
Eugenol	Eug.
Examination	Exam.
Extraction (ed) (Uncomplicated unless otherwise noted)	Ext.
Filling(s)	Fil.
Fluoride	Fl.
Fracture(s)	Frac.
General	Gen.
Gingival (itis) (state type in parenthesis).	Ging.
Gutta percha	G.P.
Impacted (ion)	Imp.
Impression	Impr.
Incised	Inc.
Inlay	Inl.
Inserted	Ins.
Maxillary	Max.
Mandibular	Man.
Partial	Pr.

Parietal	Par.
Periapical	Per.
Pericoronitis	Percor.
Periodontitis	Perio.
Porcelain	Porc.
Post Operative Treatment	POT.
Prepared (ation)	Prep.
Prophylaxis	Pro.
Reappoint (ment)	Reapt.
Recement (ed)	Recem.
Reconstruct (ed)	Rct.
Reduce (d)	Red.
Regional	Rel.
Repaired	Rpd.
Sedative (ation)	Sed.
Sequestrum	Seq.
Surgical	Surg.
Suture (s)(d)	Su.
Treatment (ed)	Tr
Unerupted	Uner.
Vincents	Vin.
Zinc Chloride	ZnCl.

(4) Space is provided in the lower right margin under Section III for the patient's name which is for convenience in filing in the dental record. Record the last name in capital letters. Do not abbreviate any part of the name.

4. SF-603-A (Dental Continuation).

a. General. Use a SF-603-A whenever the original SF-603 becomes filled or when the record cannot be satisfactorily brought up-to-date by entries on the appropriate chart.

b. Detailed Instructions.

(1) Enter individual's name and SSN in the space provided on the right margin of both the front and back side of the form.

(2) Number the continuation sheet in the upper right corner following the phrase "DENTAL-Continuation." Thus, the earliest SF-603-A is labeled "DENTAL-Continuation #1" and subsequent sheets are labeled "DENTAL-Continuation #2", "DENTAL-Continuation #3", etc.

(3) File the SF-603-A forms on top of the SF-603 form in reverse chronological order, i.e., the most recent on top.

5. SF-513, Consultation Sheet.

a. Purpose. SF-513 shall be used whenever a patient is referred to another facility for evaluation or treatment.

b. Detailed Instructions. Complete the form as detailed in paragraph 4-B-14.b.

6. Lost Dental Records.

a. Forward "stray" dental records, disposition of which cannot be determined, to Commandant (G-PIM) with a letter of explanation.

b. When a Dental Record is missing, prepare a new record. Prominently mark the Dental Record Cover (CG-3443-2) and the Health Record, Dental (SF-603) "REPLACEMENT." Request the old Dental Record from the individual's last unit or Commandant (G-PIM).

c. In case a lost Dental Record is recovered, make entries in the recovered record of any data recorded in a replacement record, then destroy the replacement record.

7. Special Dental Records Entries. When dental treatment is refused, make an appropriate entry on the SF-603/603-A, **signed by both the dental officer and patient.**

8. Dental Examination Requirements.

a. Any peculiarities or deviations from normal are particularly valuable for identification purposes and shall be recorded on SF-603 under "Remarks." Abnormalities such as erosion, mottled enamel, hypoplasia, rotation, irregularity of alignment and malocclusion of teeth, presence of supernumerary teeth, denticles, Hutchinson's incisors, fractures of enamel or teeth, abnormal interdental spaces, mucosal pigmentation, leukoplakia, diastema, hypertrophied frenum labium, torus palantinus and torus mandibularis, embedded foreign bodies and descriptions of unusual restorations or appliances are, when noted, especially useful in this connection. Malocclusion shall be simply and clearly described. Dentures and other removable dental appliances shall also be described under "Remarks".

b. When all teeth are present, and free of caries or restorations, take special effort to discover and record any abnormalities, however slight. If no caries, restorations, or abnormalities are found, make an entry to that effect on SF-603 under "Remarks."

c. Inquire about the patients' tobacco use during routine dental examinations and document. Advise users of the health risks associated with tobacco use, the benefits of stopping, and where to obtain assistance in stopping if available. Advise all pregnant tobacco users of the health risks to the fetus.

d. Oral hygiene and periodontal status at time of examination shall be recorded. Upon initial examination, complete items 5A-5C, SF-603, with additional comments placed in "Remarks" if needed. For all subsequent examinations, describe oral hygiene level and periodontal status in item 17 of SF-603/603-A.

e. For all patients 16 years of age or older, blood pressure readings shall be taken and recorded on the CG-5605 at initial and subsequent dental examinations. Although not required, the blood pressure may also be recorded on the SF-603/603-A in the "O" portion of the SOAP entry.

9. Recording of Dental Treatments on SF-600. Make entries of dental treatment on SF-600 when the patient is on the sick list and when treatment is related to the condition for which the patient is admitted. Such entries shall be made and signed by the dental officer. Notes concerning conditions of unusual interest and of medical or dental significance may be made when appropriate.

Section D - Clinical Records.

1. Purpose and Background. The Clinical Record (CG-3443-1) is the chronological medical and dental record of a nonactive duty beneficiary (dependent or retiree) eligible for health care at a Coast Guard facility. The primary reasons for compiling a clinical record are:

   a. To develop records to facilitate and document the health condition in order to provide health care and to provide a complete account of such care rendered, including diagnosis, treatment, and end result.

   b. To protect the Government, the individual concerned, and the individual's dependents: It may be used;

      (1) to provide, plan and coordinate health care;

      (2) to aid in preventive health and communicable disease control programs; in reporting medical conditions required by law to Federal, state, and local agencies;

      (3) to compile statistical data; for research; to teach health services personnel;

      (4) to determine suitability of persons for service or assignments;

      (5) to adjudicate claims and determine benefits; for law enforcement or litigation;

      (6) to evaluate care provided; and

      (7) to evaluate personnel and facilities for professional certification and accreditation.

   c. To aid in identifying deceased persons when other means may be inadequate.

2. Contents of Clinical Records.

   a. Each clinical record shall consist of CG-3443-1 with dental and medical records arranged in the following bottom to top sequence:

      (1) Left Side - Dental: CG-3443-2 Dental Record Cover* with CG-5266 (Drug Sensitivity Sticker)*, containing the following:

         (a) SF-522, Authorization for Administration of Anesthesia and for Performance of Operations and Other Procedures*

         (b) SF-603-A, Dental Record - Continuation*

         (c) SF-603, Dental Record*

         (d) CG-5605, Dental Health Questionnaire*

(2) Right Side - Medical:

(a) PHS-731, International Certificate of Vaccination*, attached to the lower right corner of the inside of the Clinical Record Cover

(b) DD-1141, Record of Occupational Exposure to Ionizing Radiation*

(c) SF-507, Continuation Sheet**

(d) SF-602, Syphilis Record*

(e) SF-601, Immunization Record*

(f) DD-771, Spectacle Order Form*

(g) SF-520, Electrocardiographic Report*

(h) SF-519, Radiographic Reports

(i) SF-514, Laboratory Reports (or SF-545, Laboratory Report Display*)

(j) SF-541, Gynecologic Cytology*

(k) SF-515, Tissue Examination*

(l) SF-522, Authorization For Administration of Anesthesia and for Performance of Operations and Other Procedures*

(m) SF-513, Consultation Sheet*

(n) SF-502, Narrative Summary*

(o) CG-5447, Occupational Medical Surveillance and Evaluation Program*

(p) DD-2807-1, Report of Medical History*

(q) DD-2808, Report of Medical Examination*

(r) SF-558, Emergency Care and Treatment

(s) SF-600, Chronological Record of Medical Care

(t) DD-2766, Adult Preventive and Chronic Care Flowsheet Form

(u) CG-5266, Drug Sensitivity Sticker*

* When required

** SF-507's are attached to and filed after the form is continued

b. File forms of the same number in their assigned sequence, with the most recent placed on top of each previous form, i.e., file SF-600 dated 3 AUG 89 on top of SF-600 dated 20 MAY 86.

c. Enter all dates on Clinical Record forms, including the Clinical Record Cover, in the following sequence: day (numeral), month (in capitals abbreviated to the first three letters), and year (numeral); i.e., 30 AUG 86.

3. Extraneous Attachments. In order to ensure that the clinical record is an accurate, properly documented, concise and dependable record of the medical and dental history of the individual, keep extraneous attachments to a minimum. When they are necessary, file them beneath all other forms.

4. Opening Clinical Records. Open a Clinical Record when an eligible non-active duty beneficiary initially reports to a Coast Guard health care facility for treatment.

5. Terminating Clinical Records. The Clinical Record shall be terminated four years after the last record entry. Make an entry on SF-600 explaining the circumstances under which the record was terminated. Forward the record to:

Dependent Records:	**Military Records**:
National Personnel Records Center	National Personnel Records
GSA (Civilian Personnel Records)	Center (MPR)
11 Winnebago Street	9700 Page Avenue
St. Louis, MO 63118-4126	St. Louis, MO 63132-5100

6. Custody of Clinical Records.

a. Clinical Records shall be retained in the custody of the Chief, Health Services Division of the unit providing care. At times when there is no medical or dental officer, the clinical record will become the responsibility of the senior health services department representative.

b. The name, grade, or rate of the health care provider making entries in clinical records shall be typed, stamped, or printed under their official signatures. Do not use facsimile signature stamps.

c. If an erroneous entry is made in a Clinical Record, the author of the entry shall draw a diagonal line through the complete entry, make an additional entry showing wherein and to what extent the original entry is in error, and initial clearly next to the correction.

d. Each health care provider is responsible for the completeness of the entries they make on any medical or dental form in the Clinical Record.

e. Nothing shall be removed from the Clinical Record except under conditions specified in this Manual.

7. Safekeeping of Clinical Records. Clinical Records are the property of the Federal government and must be handled in accordance with the provisions of the Privacy Act of 1974 and the Freedom of Information Act. Guidance in this area is contained in The Coast Guard Freedom of Information and Privacy Acts Manual, COMDTINST M5260.3 (series).

   f. Since Clinical Records contain personal information of an extremely critical or sensitive nature, they are considered class III records requiring maximum security (high security locked cabinets or areas).

   g. Except as contained in the The Coast Guard Freedom of Information and Privacy Acts Manual, COMDTINST M5260.3(series), the information contained in Clinical Records shall not be disclosed by any means of communication to any person or to any agency, unless requested in writing by or with the prior consent of the individual to whom the record pertains. It is the requestor's responsibility to obtain the consent.

8. Transfer of Clinic Records.

   a. When dependents of active duty personnel accompany their sponsor to a new duty tation, the Chief, Health Services Division, his designee, the Executive Officer, or the senior health services department representative shall ensure that the "TRANSFERRED TO" line of the health Record Receipt form, NAVMED 6150/7, is completed in accordance with Chapter 6-B-5 of this Manual.

   b. A DD 877 shall be initiated for each record transferred. **Send records using a service that provides a tracking number, such as Priority Mail Delivery Confirmation, Certified Mail, Insured Mail, or FedEx/Express Mail if time is critical,** to the Coast Guard clinic serving the gaining unit. Express mail and Federal Express should be used only when absolutely necessary and not as a general rule. In instances where the family member will not be located near a Coast Guard Clinic, the record may be mailed to the appropriate MTF. This form can be located on the internet at; http://web1.whs.osd.mil/ICDHOME/DD-0999.htm

   c. If the family members will no longer receive care through a military primary care manager, the family member may be given a copy of the clinical record contents to carry with them. The original clinical record will be retained at the clinic serving the unit where the sponsor was last assigned.

   d. Clinics will give family members written information containing address and POC information to facilitate requests for record copies after transfer. All requests for clinical record copies must be in writing. The family member may request that a copy of the record be forwarded to their new care provider once they arrive at the new location, or they may request that the original record be forwarded to their new military primary care manager once they arrive at the new location. In these cases, the clinic shall send a copy of the clinical record contents to the care provider within 10 working days of receipt of the written request. If the clinic cannot comply with this requirement for some reason, the family member will be notified within 10

working days of the request of a projected date when the record copy will be available.

e. In any instance where there is concern about potential loss of the clinical record, or that its contents may become unavailable to the treating clinic or its provider, the Clinic Administrator or the Chief, Health Services Division shall direct that copies of parts or all of the clinical record shall be made and retained at the clinic.

f. Originals and copies of clinical records shall be retained and subsequently archived in accordance with directions contained in the Paperwork Management Manual, COMDTINST 5212.12(series).

9. Lost, Damaged, or Destroyed Clinical Records.

a. If a Clinical Record is lost or destroyed, the unit which held the record shall open a new record. The designation "REPLACEMENT" shall be stamped or marked on the cover. If the missing Clinical Record is recovered, insert in it any additional information or entries from the replacement record, then destroy the replacement record cover.

b. Clinical Records which become illegible, thus destroying their value as permanent records, shall be duplicated. The duplicate shall, as nearly as possible, be an exact copy of the original record before such record became illegible. The new record shall be stamped or marked "DUPLICATE" on the cover. The circumstances necessitating the duplication shall be explained on the SF-600. Forward Clinical Records replaced by duplicate records to the National Personnel Records Center.

10. **Clinical Record Forms**.

a. CG-3443-1 (Clinical Record Cover). See Encl (1), pg 4-40.

(1) General. The Clinical Record Cover is used whenever a Clinical Record is opened on dependents or retirees.

(2) Detailed Instructions.s

(a) Last Name. Record the last name in all capital letters.

SMITH

(b) Given Name(s). Record given name(s) in full without abbreviation. If the individual has no middle name or initial, use the lower case letter "n" in parentheses (n). If the individual has only a middle initial(s), record each initial in quotation marks. When "Jr." or "II" or other similar designations are use, they shall appear after the middle name or initial.

SMITH,	Helen	(n)
Last Name	**First Name**	**Middle Name**

(c) Date of Birth. Enter day, month (abbreviated JAN, FEB, MAR, etc.) and the year; i.e., 3 FEB 77.

(d) Social Security Number. Enter sponsor's SSN.

(e) Status. Check the appropriate block; i.e., Retiree USCG, Dependent USPHS, etc.

(f) Other. Use this block to indicate special status or other information useful for either proper monitoring of the patient or for aid in indentifying the patient or record.

(g) Occupational Monitoring. Indicate the reason for occupational monitoring if monitoring is required.

(h) Med-Alert. Check this block to indicate that the patient has a medical problem that must be considered in rendering treatment; i.e., allergy, diabetes, cardiac problems, etc. Describe the specific medical problem within the medical record on Problem Summary List, NAVMED 6150/20.

b. **SF-522 (Authorization for Anesthesia, Operations, etc.).** See Encl (1), pg. 4-41.

(1) Complete SF-522 describing the general nature of the procedure and have the patient sign prior to administering anesthesia (local or general) except for dental anesthesia. Also, complete SF-522 prior to administering immunizing agents.

Insert the form immediately behind Consultation Sheet (SF-513) or as indicated in Section 4-D-2.

Section E - Employee Medical Folders.

1. Purpose and Background. The Employee Medical Folder (EMF), (SF-66 D), is the chronological medical record of Federal employees eligible for health care at Coast Guard facilities. These are the primary reasons for compiling an EMF.

    a. Develop records to facilitate and document the health condition in order to provide health care and to provide a complete account of care rendered, including diagnosis, treatment, and end result.

    b. To protect the Government and the individual concerned.

    c. The information in the EMF is routinely used: to provide, plan and coordinate health care; to aid in preventive health and communicable disease control programs; in reporting medical conditions required by law to Federal, state, and local agencies; to compile statistical data; for research; to teach health services personnel; to determine suitability of persons for service or assignments; to adjudicate claims and determine benefits; for law enforcement or litigation; to evaluate care provided; and to evaluate personnel and facilities for professional certification and accreditation.

2. Custody of Employee Medical Folders (EMF's).

    a. EMF's are the property of the Federal government handled in accordance with the provisions of the Privacy Act of 1974 and the Freedom of Information Act. Guidance in this area is contained in The Coast Guard Freedom of Information and Privacy Acts Manual, COMDTINST M5260.3 (series).

        (1) Since EMF's contain personal information of extremely critical or sensitive nature, they are considered class III records according to The Coast Guard Freedom of Information and Privacy Acts Manual, COMDTINST M5260.3 (series), requiring maximum security (high security locked cabinets or areas).Except as contained in The Coast Guard Freedom of Information and Privacy Acts Manual, COMDTINST M5260.3 (series), the information contained in the EMF shall not be disclosed by any means of communication to any person or to any agency, unless requested in writing by or with the prior consent of the individual to whom the record pertains. It is the responsibility of the requester to obtain the consent.

    b. EMF's shall be retained in the custody of the medical officer of the unit at which the individual is employed. At no time shall individual employees keep or maintain their own records.

    c. Individuals may examine their EMF in the presence of a health services department representative, providing it does not interrupt the scheduled mission of the unit and there is no information contained therein which would be detrimental to the individual's mental well-being.

d. Health services personnel making entries in EMF shall ensure that all entries, including signatures, are neat and legible. Signature information shall include the name and grade or rate. Do not use facsimile signature stamps.

e. If an erroneous entry is made in an EMF, draw a diagonal line through the complete entry. Make an additional entry showing wherein and to what extent the original entry is in error.

f. Health services personnel are responsible for the completeness of the entries made on any form while the EMF is in their custody. No sheet shall be removed from the EMF except under conditions specified in this Manual.

g. Health services personnel shall ensure that, if EMF's are located in the same office as the Official Personnel Folder (OPF), the records are maintained physically apart from each other.

3. Contents of the Employee Medical Folders.

a. Each medical folder shall consist of SF-66 D (Employee Medical Folder) with medical records arranged in the following bottom to top sequence:

(1) Left Side Dental: Leave blank.

(2) Right Side - Medical:

(a) PHS-731, International Certificate of Vaccination*****, attached to the lower right corner of the inside of the EMF

(b) DD-1141, Record of Occupational Exposure to Ionizing Radiation*****

(c) SF-507, Continuation Sheet******

(d) CG-5447, Occupational Medical Surveillance and Evaluation Program*****

(e) SF-602, Syphilis Record*****

(f) SF-601, Immunization Record*****

(g) DD-771, Spectacle Order Form*****

(h) SF-520, Electrocardiographic Report*****

(i) SF-519, Radiographic Reports

(j) SF-514, Laboratory Reports (or SF-545, LaboratoryReport Display*****)

(k) SF-541, Gynecologic Cytology*****

(l) SF-515, Tissue Examination*****

(m) SF-522, Authorization For Administration of Anesthesia and for Performance of Operations and Other Procedures*

(n) SF-513, Consultation Sheet*

(o) SF-502, Narrative Summary*

(p) DD-2807-1, Report of Medical History*DD-2808, Report of Medical Examination*

(q) SF-558, Emergency Care and Treatment*

(r) SF-600, Chronological Record of Medical Care

(s) CG-5357, Outpatient Record

(t) DD-2766, Adult Preventive and Chronic Care Flowsheet

(u) CG-5266, Drug Sensitivity Sticker*

(v) * When required

(w) ** SF-507's are attached to and filed after the form is continued.

b. File forms of the same number in their assigned sequence, with the most recent placed on top of each previous form, i.e., file SF-600 dated 3 AUG 87 on top of SF-600 dated 20 MAY 86.

c. Enter all dates in the following sequence: day (numeral), month (in capitals abbreviated to the first three letters), and year (numeral); i.e., 30 AUG 86.

4. Accountability of Disclosures. The accountability of disclosure of records, as required by the Privacy Act of 1974, will be maintained in accordance with Chapter 8, of COMDTINST M5260.2 (series). The information will be retained for five years after the last disclosure or for the life of the record, whichever is longer.

5. Opening Employee Medical Folder. Open an EMF when an eligible Federal employee initially reports for treatment.

6. Terminating Employee Medical Folders. Terminate the EMF in accordance with the Coast Guard Paperwork Management Manual, COMDTINST 5212.12 (series). Make an entry on SF-600 explaining the circumstances under which the folder was terminated.

7. Transferring to Other Government Agencies. When transferring an EMF to other agencies, complete a Request for Medical/Dental Records or Other Information (DD-877).

8. Lost, Damaged, or Destroyed Employee Medical Folders.

a. If an EMF is lost or destroyed, the unit which held the record shall open a complete new Employee Medical Folder. Stamp or mark "REPLACEMENT" on the cover. If the missing folder is recovered, insert in it any additional information or entries from the replacement folder, then destroy the replacement folder.

b. EMF's which become illegible, thus destroying their value as permanent records, will be duplicated. The duplicate shall, as nearly as possible, be an exact copy of the original record before such record becomes illegible. Stamp or mark "DUPLICATE" on the new record cover. Document the circumstances necessitating the duplication on an SF-600. Forward EMF's replaced by duplicate records to the National Personnel Records Center.

9. **SF-66 D (Employee Medical Folder).** See Encl (1), pg. 4-42. Detailed instructions are:

a. Last Name. Record the last name in all capital letters.

BROOKS

b. Given Name(s). Record given name(s) in full without abbreviation. If the individual has no middle name or initial, use the lower case letter "n" in parentheses (n). If the individual has only a middle initial(s), record each initial in quotation marks. When "Jr." or "II" or other similar designations are use, they shall appear after the middle name or initial.

BROOKS	Cecilia	(n)
Last Name	**First Name**	**Middle Name**

c. Date of Birth. Enter day, month (abbreviated JAN, FEB, MAR, etc.) and the year; i.e., 8 JUN 62.

d. Social Security Number. Enter SSN.

Section F -Inpatient Medical Records.

1. Purpose and Background.

   a. Certain Coast Guard health care facilities have the capability and staffing to provide overnight care. Overnight care is defined as any period lasting more than four hours during which a beneficiary remains in the facility under the care or observation of a provider. By definition, overnight care may last less than 24 hours or it may last several days. Overnight care is utilized when a patient's condition or status requires observation, nursing care, frequent assessment, or other monitoring.

   b. Inpatient Medical Records (IMRs). Facilities providing overnight care shall create an Inpatient Medical Record (IMR) separate from the Health Record for the purpose of recording and preserving information related to the overnight care. The IMR shall be assembled as soon as a person is identified as needing overnight care. The IMR shall contain the following forms in a TOP TO BOTTOM sequence:

      (1) **Inpatient Medical Record Cover Sheet and Privacy Act Statement**. See Encl (1), pg 4-43.

      (2) SF-508, Doctor's Orders (most recent on top)

      (3) SF-506, Clinical Record/Physical Exam

      (4) SF-502, Narrative Summary

      (5) SF-509, Doctor's Progress Notes (most recent on top)

      (6) SF-511, Vital Signs Record

      (7) SF-514, Laboratory Report Display

      (8) SF-519, Radiologic Reports

      (9) Patient Care Kardex

      (10) Medication Kardex

      (11) SF-513, Consultation sheet

      (12) Miscellaneous forms (e.g., audiograms)

   c. Abbreviated Inpatient Medical Records (AIMRs). For patients who receive overnight care lasting 24 hours or less, an Abbreviated Inpatient Medical Record (AIMR) shall be created. The AIMR shall consist of at least an Inpatient Medical Record Cover Sheet, Privacy Act Statement, and an DD-2770, Abbreviated Medical Record form. SF-545, Laboratory Reports; SF-519, Radiologic Consultation Reports; Kardexes; and other forms may be included at the discretion of the clinic.

The AIMR shall be maintained while in use, completed, stored, and retired following the same requirements as listed for IMRs below.

d. During the time that the patient is receiving care, the IMR may be maintained in a loose-leaf binder, clipboard, or other convenient device, at the facility's discretion. Devices should be chosen and maintained so that the privacy of the patient information contained therein is protected at all times. Keeping or storing the record at the patient's bedside is discouraged for privacy reasons.

e. Once the patient is released from overnight care, providers shall have 48 hours to complete their notations in the record (excluding dictated entries). All laboratory, radiologic and consultation forms shall also be included in the IMR within 48 hours of the patient's release from overnight care.

f. Dictated entries shall be entered in the medical record within 7 days of discharge. The record may be held in medical records and flagged as needing a dictated entry.

g. After all notations, lab reports, radiology reports and consultations have been entered into the IMR, the IMR forms shall be placed in a bifold paper jacket (form CG-3443-1), and secured via a two prong device. The medical records staff is responsible for ensuring that the documents are in the correct order and are stored properly.

2. Maintenance and Storage. IMRs are the property of the Federal Government and must be handled in accordance with the provisions of the Privacy Act of 1974 and the Freedom of Information Act. Guidance concerning these acts is contained in The Coast Guard Freedom of Information and Privacy Acts Manual, COMDTINST M5260.3 (series). All requirements and directions for handling and storing IMRs also apply to AIMRs.

   a. Since IMRs contain personal information of an extremely critical or sensitive nature, they are considered to be Class III records requiring maximum security (high security locked cabinets or areas). IMRs shall be stored in well ventilated and sprinklered areas. Fire-resistant cabinets or containers shall be used for storage whenever possible.

   b. IMRs shall be retained at the health care facility which created the record. IMRs will not be transferred with personnel who change duty stations. Copies of the IMR may be given to the individual if such a request is made in writing, or may be released to other persons, e.g., physicians or hospitals, if the patient requests or authorizes such release in writing. All release requests and authorizations will be inserted into the IMR cover.

   c. IMRs will be retained at the creating health care facility for two (2) years after the date the patient is released from overnight care.

3. Disposition of IMRs. The IMR will be forwarded to the National Personnel Records Center (NPRC) as described in Coast Guard Paperwork Management Manual, COMDTINST M5212.12(series), two years after the date the patient was released from

inpatient care. The NPRC requirements must be met in order for the NPRC to accept the records.

a. Records must be sent in prescribed standard cubic foot cartons. **See Encl (1), pg.4-45.** Cartons are available from the General Services Administration Federal Supply Service (FSS). The FSS stock number is NSN 8115-00-117-8344. All non-standard cartons will be returned at the expense of the originating organization.

b. NPRC does not accept accessions of less than one cubic foot. Small amounts shall be held until a volume of one cubic foot or more is reached.

c. Print the accession number on each box, starting in the upper left hand corner **See Encl (1), pg. 4-45** . Mark the front of the box only. The accession number consists of the RG, which is always 26 for the Coast Guard, the current FY in which the records are being shipped, and a four digit number assigned by NPRC (see 4-F-3.j. for SF-135 preparation). Mark the front of the box only. Ensure that the information printed on the box is not obscured in any way, and that removal of tape or other sealing materials will not remove vital information.

d. Number each box consecutively, e.g., 1 of 8, 2 of 8, 3 of 8,.8 of 8; or 1/8, 2/8, 3/8...8/8, in the upper right hand corner. See Encl (1), pg. 4-45 for placement.

e. Records shall be arranged in each storage box either alphabetically or numerically. Print the identifier of the first and last record/folder that is contained in the box on the center front of each box as shown in Encl (1), pg. 4-45.

f. Enclose in the first box of each accession one copy of the SF-135 and any alphabetical or numerical listing needed to reference the records.

g. Ship records together so they arrive at the NPRC at the same time. Shipments of 10 cubic feet or more shall be palletized as shown in **Encl (1), pg. 4-46**.

h. Records must be shipped within 90 days of being assigned an accession number. Failure to ship within 90 days will void the accession number.

i. Each clinic that transfers IMRs to NPRC must keep a master list (hard copy) of the records sent. The master list must be retained at the clinic for a period of 50 years.

j. All shipments to NPRC must be accompanied by SF-135, Records Transmittal and Receipt form. The transmittal form must include the name on the record and the individual's social security number. The accession number elements include the RG which is always 26 for the Coast Guard, the current FY during which the record is shipped, and the 4 digit sequential number assigned by NPRC. Also include the date sent. Complete SF-135 preparation and submission instructions are contained in the Coast Guard Paperwork Management Manual, COMDTINST M5212.12(series).

4. Inpatient Medical Record Forms and Required Entries.

a. **SF-508, Doctor's Orders**. See Encl (1), pg 4-47.

(1) Purpose. SF-508 is used to record written and verbal orders of the medical or dental staff; record that nurses have noted orders; record automatic stop dates for medications and time limited treatments; and record the RN review of orders which shall be performed every 24 hours.

(2) Preparation

(a) When Prepared. SF-508 shall be used to communicate doctor's orders for all persons admitted to the medical facility inpatient area.

(b) Required Entries.

1 Patient identification information may be written in or overprinted using a patient identification card.

2 The date and time at which the order is written by the provider will be listed under the start column. If a verbal order is received, the date and time at which the order was received will be noted by the person who received the order in the start column. All verbal orders must be countersigned by the admitting provider on the next working day.

3 Certain orders may be defined as time limited, e.g., complete bedrest for 24 hours, tilts q 8 hours X 3, etc. In addition, the facility shall define the length of time between renewal of orders for medications, treatments, etc. For orders which are time limited, the date and time when the order expires shall be noted under the stop column.

4 All doctor's orders shall be listed on the form under drug orders. Orders shall be printed clearly in black ink. Only approved abbreviations shall be used. Nursing staff and/or health services technicians are required to contact the provider who wrote the order if there are any questions or difficulty encountered in reading the written order.

b. **SF-506, Clinical Record/Physical Exam**. See Encl (1), pg. 4-48.

(1) Purpose. SF-506 is part of the inpatient medical record. It is used to record information obtained from physical examinations.

(2) Preparation. When Prepared. SF-506 shall be prepared when a patient is admitted to the medical facility.

(c) Required Entries.

1 Patient identification information may be written in or printed using a patient identification card.

2 Fill in the date that the exam is conducted in the upper left corner. The patient's self reported height may be used. Patients shall be weighed accurately on the day of admission and the weight entered as present weight. Vital signs to include temperature, pulse and blood pressure are recorded in the appropriate boxes. Rectal temperatures shall be identified by an "R" after the temperature reading. Axillary temperatures in adults are unreliable and will not be used.

3 A physical examination must be thorough, recorded accurately, and contain sufficient information to substantiate the treatment plan and interventions. Examination notations may be continued on the reverse of the form. If the back of the form is used, this must be indicated on the front of the form. The examiner will sign the form at the end of his/her notations and use a printed ink stamp to clearly mark name, rank, and SSN.

c. SF-509, Progress Notes. See Encl (1), pg 4-50

(1) Purpose. SF-509 is part of the inpatient medical record. It is used to record the progress of the patient's condition, therapy or other treatment(s), as well as any other information relevant to the patient's condition or treatment such as laboratory tests and results.

(2) Preparation.

(a) When Prepared. SF-509 shall be prepared when a patient is admitted to the medical facility inpatient area.

(b) Required Entries.

1 Patient identification information may be written in or overprinted using a patient identification card.

2 Fill in the left column with the date and time at which the entry is being created. Begin writing to the right of the solid brown line. Notes will be written in SOAP format (see 4-B-5.a.(4)). The person creating the note will sign the form at the end of his/her notations and use a printed ink stamp to clearly mark name, rank, and SSN.

d. **SF-511, Vital Signs Record.** See Encl (1), pg.51.

(1) Purpose. SF-511 shall be used to document vital sign measurements, height, weight, hospital day and, if appropriate, postoperative day for patients admitted to the medical facility inpatient area.

(2) Preparation.

(a) When Prepared. SF-511 shall be prepared when a patient is admitted to the medical facility inpatient area.

(b) Required Entries.

1 Patient identification information may be written in or overprinted using a patient identification card.

2 Hospital day one shall be the day of admission.

3 If the patient undergoes an invasive procedure, "op" shall be written after the word post in the left column. The day of surgery shall be noted by writing "DOS" in the appropriate column. The day following the day of surgery is post-op day one. Post-op days shall be numbered consecutively thereafter.

4 The month in which the patient is admitted shall be written on the fifth line, first column. The year shall be completed by writing in the correct numerals after "19" on the fifth line.

5 The calendar date on which the patient is admitted shall be written in on the line next to the word day, e.g., if the patient is admitted on 3 June, the hospital day is one, and a "3" is written on the line next to the word day.

6 The hour at which the vital sign measurements are to be made are noted in the spaces next to the word hour. Use 24 hour clock notations, e.g., 11 p.m. is 2300, etc.

7 Once vital signs have been measured, they shall be recorded on the form using the symbols for pulse and temperature. Symbols are placed in the columns, not on the brown dotted lines.

8 Blood pressure measurements are written in the spaces to the right of the words "blood pressure". The first measurement made after midnight is written in the top left column, the second is written below it. The first measurement made after noon is written in the top box in the right side column, the second below that, etc. Blood pressure may also be represented by x marks placed at the systolic and diastolic measurements corresponding to the scale for pulse measurements.

9 Other vital signs measurements or intake and output measurements may be written in the spaces on the lower part of the form, or a local overprint/stamp may be used.

10 Both sides of the form will be used. If the second side of the form is used, the word "continued" will be clearly written on the bottom of the first page.

e. SF-514, Laboratory Reports.

(1) Purpose. SF-514 is part of the inpatient medical record. It is used to keep laboratory report forms neat, in proper order, make them easily accessible to caregivers, and stores them as part of the inpatient medical record. SF-545, Clinical Record - Laboratory Report Display may be used in lieu of SF-514.

(2) Preparation.

(a) When Prepared. SF-514/SF-545 shall be prepared when a patient is admitted to the inpatient medical area.

(b) Required Entries.

1 Patient identification information may be written in or overprinted using a patient identification card.

2 Reports (or chits) may be attached to the form using either the self adhesive on the back of the chit, or by neatly placing a strip of clear adhesive tape horizontally across the top of the report, so that the lower half of the tape strip is touching the chit and the upper half is sticking to the SF-514/SF-545.

f. SF-519, Radiologic Consultation Reports.

(1) Purpose. SF-519 is part of the inpatient medical record. It is used to collect radiologic reports for easy access by caregivers and to store the reports with the inpatient medical record.

(2) Preparation.

(a) When Prepared. SF-519 shall be prepared when a patient is admitted to the inpatient medical area.

(b) Required Entries. Reports shall be attached to the form using the self stick adhesive on the back of the report or clear adhesive tape.

g. **DD-2770 *(replaces SF 539)* Abbreviated Medical Record**. See Encl (1), pg. 4-52.

(1) Purpose. DD-2770 is used to record history, exam findings, patient progress, doctor's orders, vital signs, output, medications and nurse's notes for patients requiring overnight care who remain 24 hours or less.

(2) Preparation.

(a) When Prepared. DD-2770 may be used for any overnight care patient for whom total stay is anticipated to be 24 hours or less. If length of stay exceeds 24 hours, a full IMR must be initiated to provide proper documentation of the patient's stay. The DD-2770 shall be prepared when a short stay patient is admitted to the inpatient medical area.

(b) Required Entries.

1 Patient identification information may by written in or overprinted using a patient identification card.

2 History, chief complaint, and condition on admission must be documented in the top box on page one. Date of admission shall be noted here also.

3 Physical examination findings shall be noted in the center box on page one. Physical exam findings shall be completely noted and appropriate to the condition. Deferred exams, such as rectal exams, shall be noted as such.

4 The patient's progress over the 24 hour period between admission and discharge will be noted by the medical officer in the third box on page one. Date of discharge and final diagnosis shall be noted here also.

5 The physician shall sign the form in the box provided and use a printed ink stamp to clearly mark his/her name, rank, and SSN. The date the form is signed shall be written in the box provided next to the signature.

6 The location of the clinic or dispensary, for example, Dispensary TRACEN Cape May, shall be written or stamped in the box marked organization.

7 Doctor's orders shall be written only in the space provided on page two. Each order group written shall be dated and signed. A printed ink stamp shall be used by medical officers to mark name, rank, and SSN. All medical and dental orders given during the patient's stay must be recorded. A second page should be started if the number of orders exceeds space available on one page.

8 Vital sign measurements shall be recorded in the spaces provided with the date and time of each notation. Bowel movements and urine output are noted in the columns marked stools and weight.

9 Medications administered and brief notes regarding the patient's condition shall be made in the nurse's notes area. Medication name, dose, route, and time given shall be recorded for each dose of medication administered. Each notation shall be signed with the name, military rank, or title for civilians, e.g., RN or LPN, of the person making the note.

Section G – Mental Health Records.

1. Active duty: Complete mental health assessments and visits will be done in an IMB, DMB or traditional psychiatric evaluation format and recorded on SF-600, SF-513, IMB, DMB, or typed psychiatric evaluation forms as appropriate. Active duty episodic visits and routine appointments will be recorded on SF-600 in SOAP format. The Objective ("O') section would include mental status observations and any other pertinent physical findings. Records of active duty mental health assessments and visits will be kept in the main health record (CG-3443). An additional separate mental health record may be created and maintained in a system of records approved by the local QA Committee and kept secure in the mental health practitioner's office. New patients would be evaluated IAW traditional psychiatric evaluation.

2. Non- Active duty: Separate records of mental health care may be created and maintained in a system of records approved by the local QA Committee and kept secure in the mental health practitioner's office. Alternatively, the mental health practitioner may elect to keep records of visits in the dependent or retiree's main based record (CG-3443-1). Should the practitioner elect to maintain a separate office based record for non-active duty patients, the main health record (orange jacket) must include, at a minimum, the diagnosis in the problem summary listing, current psychiatric medications on the SF-600, and lab work ordered by the mental health provider. New patients would be evaluated IAW traditional psychiatric evaluation. Episodic and follow up visits would be recorded in a SOAP format.

3. Psychiatric evaluation format: The psychiatric evaluation shall include, at a minimum: patient information, chief complaint, history of present illness, past history (psychiatric symptoms, diagnoses, and care medical illness, surgeries, current medications, allergies, alcohol & drug history), personal history, family history, mental status exam, assessment (DSM-IV), prognosis, and plan. Included in all assessments and other visits as appropriate will be an estimation of potential for harm to self or others. In addition, notes should contain sufficient information to establish that the criteria for any new DSM based diagnosis are met.

4. Custody of Mental Health Records: Records kept in the mental health practitioner's office are property of the CG and copies should be available to other civilian practitioners or agencies at the patient's request. These records should also be available to other CG providers, as part of an official records review process, and as directed in Section 4.A.5. of this Manual.